DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Regional Admission Policy and Procedures

March 25, 2014

On January 15, 2014, the Department of Behavioral Health and Developmental Services issued guidance to all eight of Virginia's partnership planning regions to develop written policies and procedures for accessing the appropriate level of care during mental health emergency situations. The guidance included instruction for regions to collaboratively develop written policies and procedures, communication and data sharing, quality improvement and medical screening for the use of regional private and state psychiatric beds in emergency situations. DBHDS required each region by March 15, 2014 to utilize the guidance to refine, clarify and/or develop written procedures for local CSBs to follow when seeking emergency hospital beds. Regional partnerships are comprised of area community services board executive directors, state mental health facility directors and local partners such as private hospitals, law enforcement and judicial officers. The new policies for the seven regions follow:

REGION I

HPR I REGIONAL ADMISSIONS PROTOCOL

Serving the individuals and communities for the following Community Service Boards (CSBs):

Harrisonburg-Rockingham Community Services Board, Horizon Behavioral Health, Northwestern Community Services Board, Rappahannock Community Services Board, Rappahannock-Rapidan Community Services Board, Region Ten Community Services Board, Rockbridge Community Services Board, and Valley Community Services Board.

Section 1: Purpose and Expectations

It is of critical importance to achieve a safe placement for individuals in crisis within the time limit afforded by the Code of VA. Clear and consistent procedural expectations are to be established among the stake holders of HPR I to define what steps are to be taken to seek TDO admissions to private psychiatric hospitals. This protocol establishes the process to be followed when a private hospital bed is not readily available and an admission to a state hospital is necessary. By establishing this protocol, it is the goal of HPR I to find appropriate placement for all TDO eligible individuals within the allotted time frame and to ensure that no one who requires a TDO admission be released to the community without receiving adequate treatment.

The purpose of this document is to provide a standardized protocol to be followed by preadmission screeners in seeking private hospital beds for TDO admissions and, subsequently, state hospital beds should attempts to secure a private bed prove to be unsuccessful. By establishing this protocol, it is the express goal of HPR I to find appropriate placement for all TDO-eligible individuals within the allotted time frame and to ensure that no one who requires a TDO admission be released to the community without receiving adequate treatment. This protocol applies to all potential TDO admissions, whether subject to an Emergency Custody Order (ECO), or not.

Section 2: Procedures for Seeking Private Hospital Beds for TDO Admissions

HPR I is comprised of eight CSBs that cover a large and diverse area. Over the years, the ES department at each Board has developed working relationships with a number of private hospitals. These hospitals typically are the ones closest to the CSB geographically, recognizing the best practice of hospitalizing individuals close to home and family as best as possible in order to enable families to better participate in treatment and discharge planning when appropriate. However, CSBs also have established strong relationships with private hospitals, both within the HPR I service area and outside it, that have LIPOS contracts with HPR I and utilize them for TDO admissions frequently.

The CSBs will use the standard list of private hospitals listed in the Psychiatric Bed Registry and will customize their own order of this list rather than attempting to create a "one size fits all" list of hospitals for all to use. This will allow each Board to continue to best serve their clients by utilizing those hospitals nearest to them in proximity or that have the best working relationships with them by calling them first to seek admission. Each CSB will identify five private facilities that they use the most and will list them as "Primary Private Hospitals" on their list. They will also identify ten "Secondary Private Hospitals" on their call list to contact if none of the Primary Hospitals are able to take a TDO patient. Each CSB's list of Primary and Secondary Hospitals will be made available to the Regional Manager as well as to the UMT for review as part of the Quality Improvement Process (see Section 10)

The steps taken by a CSB prescreener to secure a private TDO admission are as follows:

Step 1: Primary Hospitals with reported bed availability will be contacted first to secure a TDO bed. For the sake of timeliness and to maximize the number of private hospitals that can be called, it will be necessary for the prescreener to contact a number of these hospitals simultaneously to request a bed. It is the expectation of this protocol that private hospitals will work to give responses regarding admissions (either approving admissions or declining) as promptly as possible. Once an admission is secured, the prescreener will contact the other hospitals with referrals pending to cancel the request for a bed.

Step 2: If the search of the Primary Private Hospitals with reported bed availability is unsuccessful, the prescreener will then begin to contact hospitals listed as Secondary Private Hospitals that, according to the Psychiatric Bed Registry, have available and appropriate beds.

Step 3: If there are no available beds at any of the Secondary Private Hospitals (and there is still time remaining under the 4 hour ECO period), the prescreener will make calls to other hospitals on the HPR I Hospital List that, according to the Psychiatric Bed Registry, may have appropriate beds available.

Step 4: If time still remains under the 4 hour ECO period, and if all the private hospitals listed on the Psychiatric Bed Registry as having available beds have been contacted and the securing of a TDO bed has still been unsuccessful, the prescreener may contact their Primary and Secondary Hospitals not already consulted as part of this process. This would be done to determine if any discharges had occurred since the last update to the Psychiatric Bed Registry that might be appropriate for the individual.

For each prescreening, the CSB prescreener will document which private hospitals were called, the time the calls were initiated, the response received and the time of the responses. This documentation will be in accordance with the CSB's policies and will be particularly important should the case need to be reviewed as part of the Quality Improvement process (see Section 10)

Section 3: Procedures for Seeking State Hospital Beds When Private Beds are Unavailable

When the ECO reaches the four hour mark from the time it was served and a private hospital bed has yet to be secured, a call will be made by the prescreener to the state hospital to notify admissions staff that a TDO bed search is in process and the bed search is extending past four hours. In prescreenings that do not involve an ECO, this four hour limit will still apply and will be measured from the time the preadmission screening process commences. It should be emphasized that this call is not made to necessarily seek admission at the state facility at that time but rather to begin to collaborate with the state facility and initiate the discussion of admission should it become necessary.

If, after collaboration between the CSB prescreener and admissions staff at the state hospital, it appears that no private beds are available and a state bed will be sought, the CSB prescreener will notify their ES Manager or Designee to discuss a possible request for admission to the state facility. The ES Manager or Designee will review the request with the prescreener and, if appropriate, will authorize the prescreener to contact the state hospital to formally request admission. This review will include factors such as medical appropriateness, substance abuse issues, and other factors that may or may not indicate appropriateness for admission to a state hospital.

If a call to WSH occurs after hours (between the hours of 5 PM and 9 AM M-F, or on weekends or state holidays) it will be fielded by the WSH Information Center. Information concerning the possible admission should be faxed to them at 540-332-8144. The WSH Information Center staff will gather the information for the OD in preparation for review and approval. Once it is established by the prescreener and the CSB's designated agency contact that an admission to WSH will be sought, the Information Center staff will contact the WSH on call Intake Coordinator to screen the admission and refer to the OD for approval.

If the state facility is unable to accept the admission due to clinical factors (e.g. medical instability), they will collaborate with the CSB staff regarding other possible alternatives. If the state facility is unable to accept the patient due to capacity issues, this shall be communicated through the state facility's chain of command to arrange admission to another state facility that has an available and appropriate bed.

It is understood that, under no circumstance, should an individual who is medically appropriate and who meets TDO criteria be released from an ECO without an admission to a psychiatric facility and the disposition should not take longer than the maximum time period allowed by VA Code for an ECO/ECO extension (6 hours).

Section 4: Medical Assessment and Medical Screening Procedural Expectations

The purpose of this process is, essentially, threefold: 1) to determine that the individual who is being prescreened is not in any imminent medical danger, 2) to determine that apparent psychiatric symptoms are not the result of underlying medical factors, and 3) to help determine an appropriate facility, if hospitalization is warranted, that will have the capacity to safely manage any medical issues that the individual may have.

A basic Medical Assessment of an individual who is the subject of a preadmission screening may include the following:

- Physical Exam
- CBC
- Urinalysis
- Comprehensive Metabolic Panel
- Urine drug screen and blood alcohol level
- EKG (if indicated)

Based upon the results of the above assessment (if indicated) and/or the individual's medical history, other testing may be required before the individual can be assessed as medically appropriate for admission to a psychiatric facility. If further testing or assessment is required for admission to be considered, it is expected that the potential receiving facility communicate this to the CSB preadmission screener ASAP. The CSB preadmission screener will notify the medical staff performing the Medical Assessment of this request ASAP in order to maximize the use of the time allotted under the Emergency Custody Order or the ECO Extension.

In many cases, there will be potential dispositional issues regarding medical appropriateness for psychiatric admission between the physician performing the Medical Assessment/Screening and the physician at the potential receiving psychiatric hospital. Because the ability to appropriately resolve these issues typically requires a level of medical training that far exceeds that of most CSB preadmission screeners, differences of opinion regarding medical appropriateness will require a direct physician to physician consultation. A physician's designee may also suffice for this purpose, provided that the hospital's policies allow for that. The CSB prescreener is to facilitate this

consultation to the extent possible (e.g. provide facility phone numbers, etc.) but will not be required to ultimately resolve the medical screening issue.

Section 5: Accessing HPR I REACH Program in Cases Involving Individuals with ID/DD

In any preadmission screening involving an individual with either documented or suspected Intellectual Disability(ID) and/or Developmental Disability (DD), the HPR I REACH program will be contacted and advised of the prescreening as outlined in each CSB's Linkage Agreement with the HPR I REACH (formerly START) program . It is understood that REACH may not be able to divert a psychiatric admission at the time of the preadmission screening. However, a REACH consultation may indicate additional resources to resolve the crisis or, in many cases, begin the process of expediting discharge planning or facilitate a step-down admission to the REACH therapeutic home for an individual with ID/DD. Additionally, for individuals with ID or DD admitted to Western State Hospital, in order to ensure the most appropriate treatment options, the regional protocol entitled "HPR I ID/BH Crisis Coordination Memorandum of Agreement" (see Appendix A) may be utilized for coordination of services between the local CSB, Western State Hospital and Central Virginia Training Center.

Section 6: Substance Abuse and/or Intoxicated Individuals

WSH does not admit individuals who are intoxicated **and** have a history of significant withdrawal symptoms (i.e., seizures, DT's). WSH does not have the capability for intubation or providing ventilator support or inserting IV's if the need should arise. There is no specific cut-off point for BAL. An individual cannot be admitted if he/she is obtunded or is having difficulty breathing or regulating their airway or have an underlying medical condition that cannot be appropriately treated at WSH.

Section 7: Individuals Who Are Deaf

Only on rare occasions would a deaf individual be directly referred to a state hospital. The Admission Protocol should be followed as for any other adult person. As mandated by State Code, VDDHH (Virginia Department for the Deaf and Hard of Hearing) maintains a directory of Qualified Interpreter Services and works to remove communication barriers. DBHDS, in cooperation with the CSBs, provides comprehensive consultative services; contact Kathy Baker, Coordinator of Services at 540/213-7527.

Section 8: Children and Adolescents

As is the case with adults needing TDO admission, CSB prescreeners will seek admission to private psychiatric facilities for children and adolescents following the same process as outlined in Section 2 above. However, if no private facilities are available for admission for children and adolescents, a placement at Commonwealth Center for Children and Adolescents (CCCA) will be sought. The CCCA Admissions and Bed Management Plan (attached) is under review and further editions of it are anticipated.

Section 9: State Hospital Bed Utilization

Critical to the success of any regional admissions protocol is the demonstrated ability to derive the maximize benefit from a limited pool of resources. This is especially true of the need to keep potential state hospital "safety net" beds open to the greatest extent possible in order to make certain they are available to accommodate emergency TDO admissions when they are needed. To keep these beds free as possible, it is imperative to monitor bed utilization in the state hospitals from admission to discharge.

HPR I has historically been proactive in terms of bed utilization reviews at Western State Hospitals. CSB Liaisons meet on a monthly basis to review WSH patients who are either ready for discharge or are approaching readiness for discharge in order to collaborate to achieve successful and timely discharges from WSH as appropriate.

When an individual is admitted to WSH on a direct TDO due to lack of availability of a private hospital bed, the CSB who performed the preadmission screening will notify the HPR I Regional Initiatives Director via email no later than the start of the next business day. The Regional Initiatives Director will monitor and track all direct TDO

admissions during their stay at WSH and will collaborate, as appropriately, with the case management CSB and WSH to help facilitate discharge or transfer to either a private hospital or CSU, if clinically indicated. The Regional Initiatives Director will also maintain records of all direct TDO admissions to WSH, including date of admission, length of stay, and final disposition. This information will be reported to the HPR I Executive Director Forum, the HPR I UMT group, and the HPR I CSB Liaisons to WSH at regularly-scheduled meetings of these groups.

Section 10: Quality Improvement and Review

For a Regional Admissions Protocol to be successful and be adaptive to ongoing changes to legislation, private and state psychiatric hospital resources, and CSB resources, among other changes, there needs to be an active and robust Quality Improvement and Review process. The practical effectiveness and overall success in reaching its goals needs to be assessed on a regular basis, with feedback from every stakeholder involved in the TDO process. In addition to ongoing protocol development, the Quality Improvement process must also be responsive to resolving problems that may arise in the implementation of the protocol in a timely fashion, in order to prevent these problems from re-occurring to the greatest extent possible.

In HPR I, there currently exists organizational infrastructure that would appear to be well-suited for overseeing and administering much of the Quality Improvement process. Specifically, these would be the Regional Access Committee (RAC), the Utilization Management Team (UMT), and the Executive Directors (ED) Forum.

The RAC is composed of representatives from the eight CSBs in HPR I (typically from the Emergency Services department), representatives from the Admissions Department at Western State Hospital, the HPR I ID/DD Project Manager, and the HPR I Regional Initiatives Director. While private psychiatric hospitals do not actively participate in RAC, each CSB RAC representative is responsible for communicating and collaborating with private hospitals for cases involving individuals served by their Boards. This group meets twice each week (on Tuesday and Thursday mornings, with the exception of holidays) via conference call, but also has the ability to meet at other unscheduled times on an emergency basis as the need arises. The primary purpose of the RAC is to review potential transfers of patients from private psychiatric facilities to Western State Hospital, taking into consideration appropriateness for transfer as well as the triaging of potential transfers bases upon severity of need, acuity and dangerousness, etc. In addition, cases involving direct TDO admissions to Western State Hospital (due to lack of private hospital bed availability or other factors) are discussed in the RAC call. Because this group meets very frequently and involves so many stakeholders, it would seem logical that this group would be the first place to discuss cases that involved problematic TDO cases. If necessary, the Regional Initiatives Director will reach out to any and all private psychiatric hospitals that were involved in the case to seek further information and input from the hospitals. The RAC representative from the CSB that performed the preadmission screening in question will be responsible for staffing the problem TDO with the RAC group at the soonest RAC conference call. Through collaboration and constructive problem-solving, it is expected that the majority of problem cases will result in resolution and, in some cases, suggestions for potential changes to the protocol In all cases, the Regional Initiatives Director will notify the hospitals and CSBs that were directly involved in the problem TDO and what, if any action is recommended by the RAC team.

The UMT meets bimonthly (every other month) and is a larger group, composed of the same individuals in RAC, plus representatives from private psychiatric hospitals, HPR I regional Crisis Stabilization Units (CSUs), representatives from DBHDS, and other CSB staff, including Mental Health Directors, etc. The primary function of this group is to review the utilization of resources in HPR I to make certain that they are being used in the most effective and efficient manner possible. The HPR I Regional Initiatives Director will report, at each UMT meeting, any problem cases that were reported to and discussed by RAC, as well as provide information regarding the resolution and disposition of the cases as available. The UMT group will be tasked with providing continuous oversight of the Regional Admissions Protocol and its effectiveness and will serve as an advisory group to the HPR I Executive Directors Forum to provide any input, suggestions, or recommendations regarding potential modifications to the Regional Admissions Protocol.

The HPR I Executive Directors Forum meets on a monthly basis and, as its name implies, is composed of the Executive Directors of the eight CSBs in HPR I. However, this meeting is also attended by other stakeholders,

including (but not limited to) DBHDS, Western State Hospital, the Commonwealth Center for Children and Adolescents, Central Virginia Training Center, and the HPR I ID/DD Project Manager and the HPR I Regional Initiatives Director. The HPR I Regional Initiatives Director will include, in his monthly report to the ED Forum, discussion of problem TDO cases that were discussed by RAC and/or UMT, including dispositions and protocol revision suggestions as appropriate. The HPR I ED Forum is the organizational body responsible for establishing regional protocols and will make the final decision regarding the content of the Regional Admissions Protocol, as well as any modifications made to the protocol moving forward.

In addition, the CSBs of HPR I plan to form a work group tasked with reviewing Emergency Services protocols and procedures, in general, to promote and maintain the incorporation of national standards.

Signed:

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Nancy Cottingham, CEO, Horizon Behavioral Health Date

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Robert Johnson, Executive Director, Region Ten CSB Date

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David Deering, Executive Director, Valley CSB Date

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Brian Duncan, Executive Director, RRCSB Date

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Lacy Whitmore, Jr., Executive Director, HRCSB Date

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Ron Branscome, Executive Director, Rappahannock Area CSB Date

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Dennis Cropper, Executive Director, Rockbridge Area CSB Date

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Millard Hall, Executive Director, Northwestern CSB Date

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Dr. Jack Barber, Director, Western State Hospital Date

APPENDIX A

Health Planning Region I ID/BH Crisis Coordination

Memorandum of Agreement

Purpose:

The purpose of this agreement is to provide procedures for HPR I CSBs, Central Virginia Training Center (CVTC), and Western State Hospital (WSH) to determine where and how individuals in crisis and needing institutional emergency services would best be served. This agreement will allow for fluid movement between the intellectual disability and behavioral health systems for those persons in crisis.

Region I ID/BH Crisis Coordination Program

This procedure is designed to assure access to institutional emergency treatment services for those individuals who have a dual diagnosis of intellectual disability / behavioral health (ID/BH) or who have intellectual disability and are experiencing severe behavioral or emotional crises. These individuals often are turned away from the local hospitals or alternative community placements. Referrals would come from Emergency Services workers.

Referrals would include those persons with dual diagnosis and persons with intellectual disability who are in immediate crisis, whose behaviors pose risks of danger to self or others, and whom the community providers cannot or will not accept.

Procedures:

A. Initial Response (Refer to Region I's CSB Protocol)

B. Emergency Admissions to Private Hospitals

Community hospitals are a consideration for individuals with dual diagnosis or individuals with intellectual disability and severe behavioral issues. The CSBs will maintain a list of community providers and hospitals with pre-established agreements to provide short term emergency services. It is agreed that at the end of this short term inpatient service, the individual will return to the community again if stable and assessed as ready for discharge. In the event the person continues to display disruptive behaviors, an assessment team from CVTC may screen the individual and recommend the most appropriate facility or facilities for placement. The DSM IV-TR diagnostic criteria will be used to determine a diagnosis of Mental Retardation / Intellectual Disability.

If the CSB believes that the individual is in need of further inpatient psychiatric treatment, then it will make a referral for HPR I/WSH Regional Authorization Committee (RAC) review. RAC may request a consultation by CVTC staff through the CVTC Coordinator of Community and Social Services, to evaluate the individual. Those persons identified with an Axis I disorder considered appropriate by the Community Service Performance Contract and RAC will be considered as requiring psychiatric treatment, although placement at CVTC may be a consideration if this is most appropriate for the individual.

C. Admission Procedures to Western State Hospital

Civil admissions will be limited to individuals residing in the HPR I catchment area. The admitting diagnosis will be established by a qualified CSB staff member. Once the diagnosis has been determined for referral criteria, there will be no further debate regarding primary axis determination. The WSH Admissions Coordinator will arrange for admission during regular business hours. Referrals are only coordinated by the CSB Emergency Services.

- The CSB Emergency Services worker will ensure that the Prescreening Form is complete and as accurate as possible with appropriate primary Axis I diagnosis identified.
- All applicants must be medically screened prior to admission.
- Those individuals with dual diagnosis who have been assessed to be functioning in the moderate or mild range of mental retardation will be referred to WSH when it appears crisis issues are psychiatric in nature. These individuals will generally have an assessed IQ above 50.
- Individuals with dual diagnosis who have been assessed to have an IQ at 50 or below will be referred to CVTC when the issues are not psychiatric in nature.
- If, after consultation with the Admission Coordinator at WSH, it is determined that WSH may not be appropriate, the CSB will then contact the Coordinator of Community and Social Services at CVTC to discuss the most appropriate placement.
- Admission will be by Temporary Detention Order (TDO) to WSH if the person is in crisis has a dual diagnosis of ID/BH or a provisional psychiatric diagnosis and has an IQ score generally above 50.
- Within the timeframe of the TDO an assessment and initial treatment plan will be completed by medical/psychiatry staff at WSH to determine, if possible, the primary cause of the disruptive behavior or altered mood, and rule in/out psychiatric conditions as the primary cause of the crisis. Once this determination is made, WSH will consult with the CSB case manager and proceed with either continued hospitalization at WSH or request that the CSB begin the referral process to appropriate programs or locations.
- CSB case manager, WSH, and CVTC will discuss options and agree on the appropriate placement.
- The Civil Commitment hearing will be coordinated and scheduled at WSH and any medical/psychiatric findings will be presented. WSH and the CSB will enter the hearing with either: (1) a recommendation for no Civil Commitment or (2) a recommendation for Civil Commitment whether to a local community hospital or WSH or (3) a recommendation for CVTC emergency admission in coordination with WSH and CVTC. If the person is not committed, discharge arrangements will be coordinated with the CSB.

Emergency Admission Procedures to Central Virginia Training Center

If the decision is made that the individual is more appropriate for CVTC or placement at WSH is denied at the Civil Commitment Hearing and treatment is still felt to be needed, the qualified CSB staff would then complete the CVTC Emergency Care (21-Day) Admission Intake Form and submit this to the Coordinator of Community and Social Services at CVTC. Weekend, holiday or after-hour requests for admission will be held until the next working day. Following notification, the Coordinator of Community and Social Services or designee will follow all routine admission procedures as described below.

- A completed CVTC Emergency Care (21-Day) Admission Intake Form with attachments and all other relevant materials shall be forwarded to the Coordinator of Community and Social Services, CVTC, for admission review and consideration.
- All applicants must be screened prior to admission by CVTC staff.
- The application is reviewed by the Coordinator of Community and Social Services, CVTC, who coordinates the Admission Management Committee review.
- The Coordinator of Community and Social Services then reports back to the Director of CVTC with the Committee's recommendations.
- Pending the CVTC Director's approval, the Coordinator of Community and Social Services notifies the CSB case manager of the decision.
- All individuals accepted to CVTC using the above procedure will be accepted on a 21-day emergency basis.
- No one can come to CVTC with legal charges of any kind pending.

D. Transfers Between Participating State Facilities

CVTC Emergency admissions may begin, by necessity, at WSH due to the time of the request made by the CSB case manager. The CSB case manager and WSH may agree, at the time of the admission, that WSH is not the most

appropriate site for treatment.

- Upon Admission to WSH, if CVTC has not been notified due to time of admission (i.e. after-hours, weekend, holiday), the CSB case manager will notify the CVTC Coordinator of Community and Social Services of the admission by 10 a.m. next business day.
- A request for a screening and transfer will be made by WSH to the CVTC Coordinator of Community and Social Services.
- A screening by CVTC staff will be scheduled within 2 business days and communicated to WSH requesting staff by the end of the next business day.
- WSH will fax all documentation pertinent to the transfer request prior to the scheduled date of the screening.
- CSB case manager will complete the appropriate admission documentation and forms, depending on what type of admission is requested, and fax to CVTC prior to the scheduled date of the screening by CVTC.
- The ID Case Manager or designee will be present (in person, by telephone, or videoconference) for the scheduled screening.
- A determination regarding acceptance of the transfer by CVTC will be made and communicated within 1 business day of the screening.

Individuals that are screened for a psychiatric Emergency Admissions to WSH, may later require further stabilization at CVTC.

- WSH will contact the CSB case manager to discuss options with the ID Case Manager.
- After it has been determined by the WSH treatment team that the individual has received maximum inpatient psychiatric treatment benefit, a request for a screening and transfer will be made by WSH to the CVTC Coordinator of Community and Social Services.
- A screening by the CVTC team will be scheduled within 5 business days and communicated to the WSH requesting staff person by the end of the next business day.
- WSH will fax all documentation pertinent to the transfer request prior to the scheduled date of the screening.
- CSB case manager will complete appropriate admission documentation and forms, based on what type of admission is requested, and fax to CVTC prior to the scheduled date of the screening by CVTC.
- The ID Case Manager or designee will be present (in person, by telephone, or videoconference) for the scheduled screening.
- A determination regarding acceptance of the transfer by CVTC will be made within 2 business days of the screening. Notification of this decision will be communicated that same day.

E. Discharge Planning

All services provided at CVTC or WSH will attempt to stabilize individuals and return them to the community as soon as possible. The decision that an individual is ready for discharge is made by the treatment team (i.e., facility staff, CSB staff, individual and family members, as practicable). All parties will follow the discharge protocol.

F. Appeal Process

If the decision for emergency care admission is denied by the Committee, the Executive Director of the requesting CSB may appeal the Committee's decision to both Facility Directors and have turnaround response within 1 business day.

G. Reporting/Monitoring

The Central Virginia Training Center Coordinator of Community and Social Services and the Western State Hospital Admission Director will monitor the implementation of this agreement, provide data to the clinical directors and the directors of their respective facilities and make recommendations as to any reasonable corrective actions.

H. Review of Memoranda of Agreement

This document will be in effect for one year from date of signatories and automatically renew for 4 consecutive years thereafter, unless otherwise terminated by one party in writing. Review of said document will take place by all signatories on an annual basis from the date of signatures and will be initiated by HPR I Regional Initiatives Manager.

REGION III

Partnership Planning Region III Regional Admissions Procedures

Serving the individuals and communities for the following Community Service Boards (CSBs) and State Facilities:

Cumberland Mountain Community Services (CMCS), Dickenson County Behavioral Health Services (DCBHS), Highlands Community Services (HCS), Mount Rogers Community Services Board (MRCSB), New River Valley Community Services (NRVCS) and Planning District 1 Behavioral Health Services (PD1 BHS).

Southwestern Virginia Mental Health Institute (SWVMHI) and Southwestern Virginia Training Center (SWVTC).

These written Policies and Procedures will strengthen the regional safety net for individuals with serious mental illness including those with co-occurring intellectual disabilities and/or substance use disorders. By clearly outlining the sequence involved in seeking a bed for an emergency situation it will improve both understanding and expectations among the CSBs, state facilities, private hospitals, members of law enforcement and other public safety stakeholders.

It may be impossible to develop a policy for every contingency and variable within an emergency evaluation and search for an appropriate bed. But it is possible to outline the communication process and decision points when a safety net bed must be accessed. The search for a bed outside of the region and involvement of additional services for individuals with additional needs (Intellectual Disability, Deaf/HoH, etc.) is also outlined.

The Southwest Virginia Behavioral Health Board is the Regional Management Group for the Partnership Planning Region III (PPR III) of far Southwest Virginia. It is comprised of the Executive Directors of the six CSBs, State Facility Directors for SWVMHI and SWVTC and 6 consumer and family members from the region. The Memorandum Of Agreement for the Southwest Virginia Behavioral Health Board (SWV BHB) directs the overall management of regional projects such as the Local Inpatient Purchase Of Services (LIPOS) and Discharge Assistance Project (DAP) in the manner required by the Department of Behavioral Health and Developmental Services (DBHDS) in the Performance Contract. The SWV BHB will amend this same Memorandum Of Agreement to include these Regional Admissions Procedures and the Quality Improvement Process described within. These policies and procedures will be updated and amended as experience and necessity requires with substantive changes being made available to all stakeholders impacted by any such changes.

Regional Admission Policies & Procedures:

In order to promote care that is geographically and culturally sensitive to residents of far Southwestern Virginia, every effort will be made to utilize private psychiatric facilities within our catchment area. Only after regional resources are exhausted would CSBs approach facilities in other regions.

Accessing Private Psychiatric Facilities

- The preadmission screener will decide which facilities to contact, and in what order, based on the clinical presentation of the individual and the degree to which the individual is able to express preferences.
- The preadmission screener may access the Psychiatric Bed Registry to explore possible placement options, if time constraints and electronic access in-the-field permit.
- The preadmission screener will determine the need for and timing of initiating medical assessment of stability. Medical assessment may or may not be required by psychiatric facilities, and is dependent upon multiple factors which are better assessed in real time by the preadmission screener. See *Guidance on Medical Screening and Medical Assessment.*

- Once the determination is made that the individual requires in-patient psychiatric care and an ECO is in place, facilities are to be contacted for consideration of admission in rapid succession. The preadmission screener will not wait for decision of admission before approaching the next facility.
- Once the determination is made that the individual requires in-patient psychiatric care and there is no ECO in place, the number of psychiatric facilities called and the pace at which they are called will be determined by the preadmission screener.
- Private psychiatric facilities will have 20 minutes within which to provide notice of acceptance or denial of admission to the preadmission screener.
- If a private psychiatric facility has made no response within 20 minutes of the referral, this will be considered a denial of admission. If a facility determines to accept the referral after the 20 minute time period, they should contact the preadmission screener with the decision.
- The preadmission screener will maintain a list of psychiatric facilities called in pursuit of admission. The list, at a minimum, will include name of facility contacted, name of staff spoken to, time of contact, and referral outcome. This list will be provided along with the Preadmission Screening Form to the state-level facility, if that facility is ultimately contacted for consideration of admission.
- For those circumstances involving an ECO, the preadmission screener must call **at least** 15 minutes before the culmination of the initial 4-hour ECO time period to request the extension. The call requesting ECO extension may be made earlier, but never later than 15 minutes.

Accessing State-Level Psychiatric Facilities

- A minimum of two or three private facilities will be called prior to contacting a state-level facility, dependent upon the CSB. Some CSBs will only have two facilities within a similar radial distance as the SWVMHI.
- An exception to this rule occurs when an ECO is in place and one-half of the total time has passed (i.e., 2 hours on the initial 4-hour ECO; 1 hour on an extension). The state-level facility is to be contacted when one-half of the total ECO time has passed. SWVMHI Admissions Protocol (below) details their internal procedures for referrals for admission.
- When the preadmission screener assesses the situation as requiring possible state-level admission, assessment for medical stability will be immediately facilitated. See *Guidance and Procedures for Medical Screening and Medical Assessment.*
- Within our region, SWVMHI is the first state facility to be called in pursuit of placement for adults and geriatric persons who have no violent felonies, with the exception noted in *Referral of Forensic Patients to the Central State Hospital Forensic Unit*.
- Referrals are made to Central State using guideline *Referral of Forensic Patients to the Central State Hospital Forensic Unit*.
- Catawba Hospital is the first state-level facility contacted by NRVCS for geriatric admissions.

SWVMHI Admissions Protocol

- The Pre-Screener will call the Nurse/Admissions Coordinator, (referred to hereafter as “SWVMHI staff”) who receives this alert on a specified pager. The SWVMHI staff member will then promptly contact the referring Pre-Screener. Should the call pertain to potential geriatric admission, the SWVMHI staff member will then contact the Geriatric Unit for further follow-up.
- Pre-Screener conveys initial information to begin process, recorded by SWVMHI staff on SWVMHI *Admission Cover Sheet*. (Attachment X)

- SWVMHI staff member also completes the *Call Processing Checklist*, recording information about successive procedural steps and the times at which they occur. (Attachment Y*)*
- Pre-Screener faxes Pre-Screening and any other relevant information (hereafter referred to as "Admissions Packet," or AP) to SWVMHI staff member.
- SWVMHI staff member promptly delivers AP to Medical Officer of the Day (MOD)
- MOD reviews AP and, within 20 minutes, contacts the evaluating physician to consult as to medical stability for transfer. If the MOD is attending to another issue of an emergent nature, call may be delayed.
- If additional information is required for a final disposition on medical stability for transfer issues, MOD will relate this directly to attending physician.
- When medical stability disposition made, MOD will promptly inform the SWVMHI staff member and return the AP to him/her.
- SWVMHI staff member will contact Pre-Screener to communicate disposition.
- On individuals accepted for admission, SWVMHI staff member will then submit Admission Cover Sheet and Call Checklist to Patient Registrar for data entry purposes.
- Upon conclusion of admissions referral process, the Admissions Cover Sheet and Admissions Checklist will be placed in Admissions Coordinator's internal mailbox for review.

Procedures When No Accepting Bed Is Located

- If there is no accepting private facility, the individual meets TDO criteria, and there is an ECO, the preadmission screener must call the state-level facility as soon as practicable but not less than 60 minutes prior to the end of the ECO time period.
- If there is no accepting facility after calling the state-level facility, the preadmission screener (after consultation with supervisor) or their supervisor will contact the state facility and ask to speak to the "clinical administrator on call" and inform them of the circumstance.
- The "clinical administrator on call" will contact the director of the state-level facility or their designee. The director or the designee will work to secure bed space either at the state-level facility, or at a sister facility.
- In the meantime, if the person is being assessed at a medical facility or a psychiatric facility the preadmission screener may attempt to facilitate/advocate medical admission or to maintain the current admission.
- In the meantime, the preadmission screener may attempt to call psychiatric facilities that previously denied admission to facilitate reconsideration.
- In the event that the private facilities and the state facility contacted do not have available beds, the SWVMHI Facility Director (or designee) will be consulted regarding approval of an admission above normal capacity on an emergency basis and/or contact the Director of another state facility to serve as back-up.
- If the above occurs, that SWVMHI is operating over capacity and/or that another state facility is serving as emergency back-up to the region, on the next working day, the region's Community Services Boards will conduct an emergency review and discharge planning effort in conjunction with SWVMHI staff for the individuals from their catchment area who are at the state hospital(s).

Procedures when Preadmission screening occurs without an ECO

- When the PAS is conducted without an ECO, the preadmission screener will monitor for any escalation of risk or change in the voluntary status of the individual and request an ECO or law enforcement assistance to mitigate risk to the individual and/or others.
- When a PAS results in a recommendation for TDO and there is difficulty in finding a bed at a private psychiatric facility, the prescreener will contact SWVMHI after all reasonable options have been exhausted. Without the time constraints of an ECO, the decision about when during the process to contact SWVMHI will rely on multiple factors. These would include; but be limited to, the individual's

willingness to participate in the evaluation, assessment of risk, medical stability and demands for other clinical assessments.

- If the PAS has resulted in a recommendation for TDO and the individual refuses continued interventions or elopes from the assessment, the prescreener will request an ECO from the magistrate to complete the PAS or TDO as appropriate.

Managing the Admission of Those with Intellectual Disabilities

- When the preadmission screener suspects or has knowledge that an individual being evaluated has a co-occurring Intellectual Disability, the REACH representative will be contacted. The ID case manager may also be contacted. The REACH staff person may participate in the evaluation and provide assistance/information to the pre-screener.
- If the individual meets the criteria for hospitalization, REACH and the ID case manager will work with the receiving facility. If the individual does not meet criteria and is not hospitalized, refer to the attached *REACH Emergency Crisis Facility Admission Flowchart,* provided by REACH Regional Coordinator.
- The preadmission screener will document on the preadmission screening form, if applicable, the name and contact information for the ID case manager and the REACH staff person that will be involved with the individual during the hospitalization.

Managing Children's and Adolescent Admissions

- The Commonwealth Center for Children & Adolescents (CCCA) is the only state facility for those under the age of 18. The 48 beds at CCCA are limited but valuable resource for the Commonwealth. Every effort will be made by CSBs to access local, regional or even extra-regional private beds for children and adolescents in need of emergency hospitalization.
- As with adult admissions, when the expiration of an ECO time limit is a possibility while contacting private facilities; the pre-screener will contact CCCA to inform them of the developing situation.
- As a resource to the Commonwealth, CCCA may be able to suggest alternatives outside of the region if they are near capacity or may begin the referral process to their facility. See the *CCCA Bed Management Plan*. (Attachment Z)
- If the pre-screener is completing a crisis referral or admission via TDO and there is not an ECO, then the clinical presentation of the youth along with risk-assessment will drive the decision to contact CCCA for guidance and possible referral.

Managing the Admission of Those who are Deaf or Hard-of-Hearing

- Preadmission screeners follow the guideline *Serving Deaf and Hard-of-Hearing Consumers In Crisis Situations,* provided by the Regional Deaf Services Program.

Utilization of Crisis Stabilization Units

- CSUs will be accessed primarily by the CSB associated with their operation.
- CSUs will admit those individuals with whom they can maintain a primary focus on the prevention of exacerbation of critical symptoms that could ultimately result in a more restrictive placement. The individual and their symptoms should be amenable to treatment in an unlocked, less secure environment.
- The director of the CSU will be called for consideration of out-of-area referrals.
- A denial of admission from a TDO capable CSU will be counted as a private denial when seeking TDO placement.

Quality Improvement Process

- PPR III will adopt a Quality Improvement Process that will regularly review issues and problems that arise during the disposition of the civil commitment process.

- Policies & Procedures for this QI Process are attached to this Regional Admissions Procedures.
- Existing policies and procedures, after action reports, modifications and issues of compliance will be reviewed and communicated on a monthly basis within the region's Census And Review Team (CART). The CART serves as the regional authorization committee for LIPOS and census management issues at SWVMHI.
- Observations and recommendations for improvement will be communicated to CSBs, SWVMHI, private facility partners and law enforcement as they are identified. Regular reports on these QI Process activities and their resolutions (solutions) will be routinely reported to the SWV BHB as well as the DBHDS as requested.
- These policies can be seen in *PPR III Quality Improvement Process* and the *Critical Event Reporting Form* attachments.

Census Management

- PPR III reviews and manages the census at the SWVMHI through the regional workgroups, CART and RDAP.
- The CART meets each Monday to review LIPOS utilization, admissions and transfers to SWVMHI and also the SWVMHI monthly statistics by individual CSBs. These will include; number of admits, number of discharges, length of stay and total bed days.
- Transfer requests to the SWVMHI are managed by a regional review of requests for available beds and prioritization of those most in need of transfer when there are more requests than beds.
- The RDAP meets monthly and reviews the Ready For Discharge (RFD) and the Extraordinary Barriers List (EBL) from the SWVMHI. Notes on progress of individuals, barriers for community placement and plans to support the discharge are discussed by the regional workgroup.

Guidance and Procedures for Medical Screening and Medical Assessment.

The purposes of the medical screening is to attempt to make sure that the individual is not experiencing a serious medical event that is masquerading as a psychiatric disorder or being concealed by a psychiatric disorder and that the receiving facility can provide the medical care the individual needs.

This procedure contains key elements that will be further detailed in the forthcoming "*DBHDS Medical Screening and Medical Assessment: Guidance Materials*," developed in joint fashion with the key stakeholders.

Psychiatric hospitals and units typically have fewer medical and medical nursing resources than hospital medical and surgical units. These free standing psychiatric hospitals and psychiatric units may lack access to immediate labs or other tests (especially on a STAT basis), have no electronic monitoring capability, may not be able to provide IV fluids or medications, and may have less clinical experience on hand at both the Nursing and Physician level.

Examples of conditions which typically cannot be managed safely in these psychiatric settings include acute delirium, head trauma, unstable fractures, unstable seizure disorders, active GI bleeding, bowel obstruction, acute respiratory distress, sepsis, overdoses, open wounds, surgical drains, severe burns, intracranial bleeds, pulmonary embolus, acute drug withdrawal with autonomic instability, active labor, major serum electrolyte abnormalities, and so forth.

A typical psychiatric unit can monitor vital signs non-invasively, provide oral medications, monitor fluid "input and output," monitor pulse oximetry intermittently, institute common preventative actions, and observe for signs of distress. Units that are part of general hospitals have more immediate access to emergency medical care, STAT labs and other tests, but typically no more capacity to provide more intensive medical treatment.

Preventative monitoring and management of some drug or alcohol withdrawals can typically be done. Pregnant patients (other than high risk), individuals with HIV, individuals with type I diabetes, individuals with PEG tube feedings, and those requiring a wheelchair can typically be managed safely. Physical therapy may be available. Nursing interventions to prevent decubitus ulcers, oropharyngeal aspiration, bowel obstruction, and transmission of most communicable diseases are generally possible.

During the Pre-Admission Screening (PAS), information will obtained on past and current medical illnesses and conditions, previous psychiatric hospitalizations and medical hospitalizations, psychoactive and other medications used, and substance use or dependence, including risk for intoxication and/or substance withdrawal. If an individual is already under care of a medical facility when the PAS is requested then EMTALA regulations governing screening, stabilization and transfer will apply. And in the event that transfer seems indicated from the PAS, then the treating physician and receiving facility will make the determination of medical stability and appropriateness of such.

Given the complexity of both human illness and health care systems, each case is to be reviewed with consideration of the individual's needs, the resources of the receiving facility and the resources of the local medical community. When medical conditions are assessed to determine if they are both stable and within the capabilities of a receiving facility, these decisions shall be rendered in a timely manner by both the sending and receiving facility. The prescreener will be responsible for notifying both the evaluating facility and receiving facility of elapsing time on the ECO.

Admission Cover Sheet **Revised 03/2014**

AB – Ext. 208/409 CD - Ext.212/ 419 F - Ext. 209/435 Karol Shepard – Ext. 250

Section I to be completed by the Admission Call person:

Date: _____

Client's name: _____ DOB: _____ SSN: _____

Facility / CSB / Pre-screener's name: _____

Caller / Pre-screener's contact phone number: _____

Current location of client:_____

Admission Legal Status: ☐ **Voluntary (8 hr. notice)** ☐ **Voluntary before Judge** ☐ **Involuntary** ☐ **TDO**

Forensic, what are the charges?_____

Does the client have a current or previous history of aggression? _____

Medical / Psych Facility / Emergency Dept. phone number:_____

Medical / Psych Facility / Emergency Dept. MD name: _____

Admission call person signature: _____

Section II to be completed by the MOD/Attending on duty:

Time MOD spoke to E.R. Dept. Physician or Medical Professional: _____

From the clinical information provided by the transferring facility / Medical Professional, does the review indicate that the client's medical needs can be met at this facility? ☐ YES ☐ NO
(If no, document medical issues / concerns on back of form)

Admission call person notified of acceptance? ☐ **YES** ☐ **NO** **Time notified:** _____

Attending / MOD signature: _____

Section III to be completed by Admission Call person:

Date / Estimated time of arrival: _____ Actual time of arrival:_____

Check Team Assigned to: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ Other: _____

Avatar Codes: Reason for admission:_____ Referral Source: _____
Admission call person signature:_____

Fax Numbers: AB: 276-783-0825; CD: 276-783-0824; F: 276-783-0816; Admission suite: 276-783-1216

Call Processing Checklist

Patient's Name: _____

Section I

1. Initial Request for Admission received at:_____ (time)

2. Contacted prescreener at: _____ (time)

3. Received initial admission packet (AP) information at: _____ (time)

   AP is:

   ☐ Legible
   ☐ Complete

4. Emergency Custody Order Issued? ☐YES ☐NO (if YES, time issued_____)

   NOTE: Contact Administrator on Call (AOC) if:

   ☐ Felony charges
   ☐ Referral from community nursing facility
   ☐ Referral from outside SWVMHI catchment area
   ☐ TDO referral when census at capacity (see capacity guidelines in call book)

5. AP delivered to Medical Officer of the Day (MOD) at: _____ (time)

6. AP received from MOD, with disposition regarding medical acceptability at: _____ (time)

7. Contacted prescreener to notify of disposition at: _____ (time)

8. If individual accepted, notified:

   ☐ Admissions clerk
   ☐ Staffing Nurse Coordinator (SNC)
   ☐ Receiving ward/unit (if different from one taking call)

Section II

9. Admissions clerk/SNC notify AOC if:

   ☐ There is admissions paperwork/legal question
   ☐ Treatment team rotation question

Referral of Forensic Patients to the Central State Hospital Forensic Unit

(November 21, 2012)

This protocol is intended to provide guidance to state facilities regarding when forensic admissions should be considered for referral to the Central State Hospital (CSH) Forensic Unit. The presumption is that local civil beds are the default admission location except in more serious criminal cases. The following guidelines apply to persons admitted to DBHDS facilities pursuant to court orders for the following: pretrial evaluation (19.2-169.1 and 19.2-169.5); competency restoration (19.2-169.2); emergency treatment (19.2-169.6). The placement of persons adjudicated unrestorably incompetent (19.2-169.3) currently in jail or housed in the community and civilly committed, while rare, should generally be considered along the same general guidelines.

General Guidelines

1. If a patient is out on bond, but has pending legal charges and has been ordered for inpatient admission, from a risk perspective he/she should be treated like any other civil admission and should therefore be admitted to a civil hospital in the absence of extenuating circumstances.
2. If a patient is an insanity acquittee on conditional release, unless he/she is being revoked for serious/dangerous violations he/she should be admitted to a civil hospital (regardless of whether he/she was conditionally released straight from the maximum security unit at CSH).
3. The presence of a felony charge should not result in automatic referral to CSH. Each potential admission should be treated on a case-by-case basis with consideration of the following factors: current level of aggressiveness in jail, history of assaults/violence, history of violence during previous admissions to a state facility, significance of escape risk (facing long [10+ years] prison sentence), other/previous violent crimes, particularly heinous aspects of history/crime, and history of victimizing frail/mentally ill. Presumption is that defendants will be admitted to a civil hospital in the absence of significant behavioral and legal considerations.

The following is a list of charges which may lead to placement in the CSH Forensic Unit. The list is in no way exclusionary, and these charges should not automatically lead to CSH admission in every case. Please see the "Comments" section for each charge for additional guidance. Each admission must be decided on a case by case basis. For guidance regarding the admission of new insanity acquittees for temporary custody, please consult the *Guidelines for the Management of Persons Found Not Guilty by Reason of Insanity.*

Charge	Code Section	Comments
Murder	18.2-31, 18.2-33	Given the escape risk, individuals charged with murder will rarely be placed in a civil hospital, but it may be appropriate when the defendant is significantly impaired or incapacitated, and currently not aggressive.
Malicious Wounding	18.2-51	Less serious offenses may be admitted to a civil hospital, particularly if there is no other history of serious aggression and the person is not currently aggressive.
Escape from jail or correctional facility	53.1-203 18.2-477	If jailed on other offense, but has history of escape, then will likely need to go to CSH.

Kidnapping by Force	18.2-47	Individuals charged with abduction not involving physical aggression may be appropriate for civil hospital placement.
Rape, Sexual Assault,	18.2-67 18.2-61	Those charged with less serious sexual charges, but that involve preying on sick/vulnerable individuals may go to CSH. Individuals charged with Indecent Exposure, Statutory Rape, or Sexual Battery may be considered for civil hospital placement, with consideration given to their known history of sexual offending, if any.
Participating in Riot	18.2-405	The defendant's history, current presentation, and dynamics of the alleged offense must be taken into consideration. Some individuals with this charge may be appropriate for civil hospital placement.
Robbery with Use of Firearm	18.2-58	Individuals with this charge will rarely be placed in a civil hospital, but it may be appropriate when the defendant is significantly impaired or incapacitated, and currently not aggressive.
Probation Violation for serious crimes	18.2-479	If facing imposition of large period of incarceration, then may go to CSH
Assault & Battery on Police Officer	18.2-57	If assault is serious/malicious admission to CSH may be necessary; however, many individuals with serious mental illness who incur this charge can be appropriately placed in a civil facility.
Assault & Battery (Misdemeanor)	18.2-57	Such cases can typically be admitted to civil hospitals unless there are unusual or extenuating risk factors.

REACH Emergency Crisis Facility Admission Flowchart

Client and primary team recognize psychiatric or behavioral crisis they feel puts individual at risk

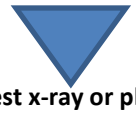
Contact local emergency services and 1-855-887-8278

Emergency services evaluates for psychiatric hospitalization while REACH co-evaluates for services. If individual meets criteria for hospitalization→ Indiivudal is hospitalized, REACH continues to follow through to facilitate discharge. This may include step down to REACH respite house. If individual does not meet criteria for hospitalization and is psychiatrically cleared:

REACH on call staff determines with REACH crisis services what service may be appropriate

If REACH on-call staff determine that the respite facility may be an appropriate service, they contact the on-call REACH supervisor

REACH on-call supervisor determines whether admission to the Respite facility is possible or appropriate, based on space availability and other current guests. If admission is not appropriate or available->REACH will attempt to locate or develop other resources that may include community/home based plan. If admission is approved:



Individual must be medically cleared, to include a chest x-ray or physician clearance of TB/other communicable disease. Signed prescriptions for all medications, and all medications must be in original containers. All documentation must be faxed to the respite facility (540) 267-3323. Admission is not approved and team should not transport until verification has occurred that all documentation has been received and reviewed at respite facility.

If admission is approved, REACH Coordinator and primary team must arrange transportation to the facility. REACH should not be relied on to be the primary transportation provider, but will assist as able.

Within 48 hours, the REACH Coordinator will schedule an admission meeting or conference call will be scheduled to discuss goals of respite and set tentative discharge date. REACH Coordinator will be the point of contact for communication while individual is at the REACH Respite facility.

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS

Bed Management Plan
2/3/14

DBHDS maintains only 48 acute inpatient psychiatric hospital beds for Virginians who are under 18 years of age. These beds are at the Commonwealth Center for Children & Adolescents (CCCA) in Stanton, which serves the entire commonwealth. With this 48-bed limit, CCCA and its community partners, including private hospitals, juvenile detention and correctional centers, and community services boards (CSBs), have been successful in meeting all emergency hospitalization needs utilizing the plan below.

CCCA serves as the safety net for children and adolescents who require acute inpatient psychiatric care and cannot be admitted to or remain in any other child/adolescent psychiatric hospital in Virginia. All valid referrals are accepted for admission assuming adequate exploration of alternative placements, medical clearance, and available bed space. To date the system has been able to meet the emergency placement needs of all children and adolescents through appropriate diversions and bed management at CCCA through discharge planning.

Unlike the eight regional DBHDS psychiatric hospitals serving adults, CCCA does not have a back-up hospital within the system to accept patients if full. This, along with a high volume of admissions and a short average length of stay, intensifies the need for active and effective bed management at the facility and community levels. In addition to the steps taken by CCCA and community partners related to admissions and discharges described below, it is of course the case that adequate support for community-based crisis management services, as well as those services providing pre-crisis interventions, will both prevent hospitalizations that would otherwise be necessary and aid in more rapid discharges, thus preserving space at CCCA for necessary admissions and maximizing the number of children and adolescents who can be served close to home.

Admissions Process

- CCCA accepts referrals of young people up to 18 years of age who are in need of inpatient psychiatric hospitalization from the entire Commonwealth
- Our Intake/Admissions Office is staffed 24 hours a day, 7 days a week, and we accept admissions 24 hours a day, 7 days a week (540-332-2120)
- Other than admissions ordered pursuant to VA§ 16.1-275 or 16.1-356 (court-ordered evaluations), all admissions must first be prescreened by a CSB
- Any calls not from CSBs (other than in cases of VA§ 16.1-275, in which we still request though cannot require a CSB prescreen), are referred to the CSB for appropriate pre-admission prescreening
- Our Intake/Admission Specialist consults in every referred case with the CSB Emergency Services Prescreener to
    - Gather information about the reasons hospitalization is being considered and alternatives that have been tried and that may be available
    - Reviews all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act
    - Consider the need for hospitalization, and if hospitalization is needed the availability of other options, particularly those that keep the child or adolescent close to home
- While the Intake/Admission Specialist may encourage the prescreener to explore options not considered, including providing names of alternative hospitals, we will accept any child/adolescent who is ultimately determined by the CSB to need emergency hospitalization and has no other option
- There is no minimum number of other hospitals that must be called; admission elsewhere will be encouraged if possible, with greater emphasis if the child/adolescent is from far away and/or we have fewer available beds
- The Uniform Prescreening Report must be received prior to acceptance for admission
- If there are active medical issues, the Intake/Admission Specialist will consult with our on-call physician to determine if medical clearance is necessary

- The specific process (method of transport, ways of obtaining consent, etc.) is dependent on the type of admission (e.g., Voluntary, Involuntary, Objecting Minor, TDO) and the specific needs of the child/family
- In cases in which we believe an admission to be inappropriate, we may exert considerable pressure on the community to identify alternatives. Assuring the appropriateness of admissions serves to prevent unnecessary and possibly distressing separation of the child/adolescent from his/her community, avoid unnecessary resource utilization, and maintain available bed space for appropriate admissions

Bed Management

A. Diversion

The only time CCCA would defer a valid admission is if it is at or very near capacity. Because the 48 beds are the only public acute psychiatric beds for the entire Commonwealth, and because admissions are unpredictable and may be heavy (e.g., 20 or more admissions in a week or 5 or more admissions in a day) there are times when capacity becomes an issue. When we are near or at capacity, we

- Contact CSB Emergency Services Departments and inform them, noting our available beds at the time and requesting that they divert if at all possible,
- Forensic admission referrals for Court Ordered Evaluation pursuant to §16.1-275 of the Code of Virginia will be placed on the CCCA Waiting List and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Court Ordered Evaluations are ordered for children not in psychiatric crisis, but for whom an evaluation of treatment needs is warranted. These children are most often in detention centers and therefore in a safe place to await admission to CCCA.
- Forensic admission referrals for Evaluation of Competency to Stand Trial pursuant to §16.1-356 will be placed on the CCCA Waiting List and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Such children are in juvenile detention centers or in the community as determined appropriate by a judge and will remain in that setting to await admission.
- When no bed space is available at CCCA for emergency civil voluntary or involuntary admissions meeting criteria per the Code of Virginia who have been prescreened and found to be appropriate for admission by a CSB, attempts will be made to implement a crisis/safety management plan and maintain the child in the community or in the present placement until bed space at CCCA is available
- If these diversionary strategies are not possible, attempts will be made to divert the child to a private inpatient facility utilizing TDO admission, Medicaid, or other third party means.
- Consider refusing admission for patients who are in a safe place (e.g., another facility or detention) until space becomes available
- If diversion attempts are not successful, child will be placed on a waiting list for admission to CCCA. CCCA waiting lists will be prioritized in consultation with CSB referral staff, taking into account acuity of the situation and safety of the child.

B. Discharge

The availability of beds for admission is dependent on patients being discharged when clinically appropriate. Clinical teams always work closely with families and communities to facilitate timely discharge, working together to manage challenges that include delays before desired community-based resources become available or the absence of such resources, differences of opinion about clinical readiness for discharge or discharge placement options, transportation availability, etc. When CCCA nears capacity, we also

- Encourage families and communities to rapidly identify and develop discharge options and support plans
- Discharge any patients who may be safely discharged but remain in the hospital based on clinical discretion

Serving Deaf and Hard of Hearing Consumers in Crisis Situations.

Regional Deaf Services Program (RDSP), Southwest, Virginia.

Administered by Cumberland Mountain Community Services, serving:
Highlands Community Services, Dickenson County Behavioral Health, Planning District One/Frontier Health, Mt. Rogers Community Services and New River Valley Community Services.

Mental health crisis situations with deaf and hard of hearing persons can be stressful for both consumer and clinician. The obvious and immediate challenge is to bridge the communication gap between provider and consumer to allow services to be rendered as they would in a similar situation with a hearing person. This paper suggests a four-tiered response process and is meant to serve as a resource for crisis clinicians.

Tier One: Contact the Regional Coordinator (RC) of Deaf Services (Mike Bush, LPC), for direct assistance 24/7/365. Mike is fluent in sign language and a certified pre-screener. In most circumstances, Mike is immediately available to drive to the site of the prescreening and conduct the clinical portion of the crisis evaluation. Mike can be reached on his cell phone 24/7 at **(276) 971-7672** and will make every effort to assist by conducting the prescreening, providing consultation, or providing an outpatient appointment to meet with the client the next business day.

Tier Two: If you are unable to reach the RC, contact a qualified sign language interpreter to assist you. Attached is a list of recommended interpreters in the area who can serve as a resource for mental health emergencies. Your CSB is required to pay for the interpreter, but an interpreter fund administered by Valley CSB will reimburse at a rate of 50% as funds are available. Contact the RC, after the fact, for forms and details. Please refer these patients immediately to the Regional Deaf Services Program.

Tier Three: (Coming soon!!!) Use a Polycom system to connect to a 24/7 remote video interpreter.

Tier Four: Document that your efforts to gain assistance in Tiers 1-3 were unsuccessful. Do the best you can to conduct a sound clinical evaluation. Try to communicate directly with the individual. Make sure your environment is quiet and well lit. Make sure the light source is above you or shining on you, not behind you. Speak in your normal tone of voice, a little slower than usual, and make eye contact while speaking. Talk *about* communication with the consumer. Assess your ability to communicate with the individual before gaining clinical information. Ask open ended questions and see what response you receive. Ask the same question in different ways if necessary. Take your time. Use family members to interpret with great caution; be aware of whether the consumer is placing a family member in an interpreting role, or if the family member is placing themselves in this role.

Inpatient Resources.

The Mental Health Center for the Deaf at Western State Hospital (WSH) no longer exists and is no longer a crisis option for our pre-screeners. WSH continues to serve deaf consumers from their own region and may accept a transfer from SWVMHI. Follow normal protocols for seeking local inpatient admissions. SWVMHI now has experience serving signing deaf adults and hiring interpreters to make their services accessible.

List of Sign Language Interpreters for Mental Health Crisis Services, New River Valley Area

Name	Number	Location	Notes
Ann Comstock	(540) 674-1077 Home	Dublin	Nationally Certified
Rachel Cooke	(276) 228-5267 Home	Wytheville, VA	Nationally Certified

	(910) 474-6163 Cell		
Angela DeVore	(540) 381-1883 Home (540) 320-4123 Cell	Christiansburg, VA	Nationally Certified
Vicki Mather	(540) 389-1466 Home (540) 798-9208 Cell	Salem, VA	Nationally Certified
Christine Romp	(540) 921-1525 Home (860) 480-0004	Pearisburg	Nationally Certified
Kay Seib	(540) 563-0985 Home (540) 529-6463 Cell	Roanoke, VA	Nationally Certified
Jerome Thomas	(540) 674-5076 Home (540) 616-6878 Work	Dublin, VA	VQAS Level III
			.
Deborah Beavers	(276) 620-5773 cell	Wytheville, VA	Nationally Certified

PPR III Quality Improvement Process

The Quality Improvement Group serves to address concerns with the PPR III admission and civil commitment process. The group will convene at least monthly either face-to-face or by teleconference for the purpose of identifying problems, investigating causes, review utilization data propose or develop solutions that assures effective collaboration and prevents reoccurrence of identified issues. Discussions and work of the QI Process group shall be considered Privileged and Confidential pursuant to Virginia Code § 8.01-581-17.

Events addressed by the group include Preadmission Screenings (PAS) approaching ECO time limits, other process improvement issues, and Critical Events. Critical Events include: PAS's exceeding ECO time limits, PAS's requiring Facility Director involvement, and PAS's resulting in the failure to obtain a bed for persons requiring a TDO. Monthly meetings of the QI Process group will review all of the events listed above and report on a regular basis to the Southwestern Virginia Behavioral Health Board and to the DBHDS as requested. In addition to these monthly meetings, for Critical Events Post hoc meetings will occur the next business day convened by the region's Project Manager. These Post hoc discussions and proposed solutions of a Critical Event shall be made part of the monthly QI Process meeting. The monthly QI Process meetings shall occur as part of the regularly scheduled regional authorization committee, Census And Review Team (CART), that meets each Monday and will be scheduled for the second Monday of each month. The CART is attended by the ES Director (or designee) of each CSB in the region as well as the SWVMHIs Facility Director (or designee), admissions officer, social work director(s) and clinical directors.

Personnel included in the monthly QI Process meetings includes: ES Directors or designees from each CSB in the region, the SWVMHI Facility Director or designee, and may include other invited stakeholders relevant to discussions of process improvement. Post hoc meetings shall occur as soon as possible after the Critical Event (typically the next business day). Convened by the regional manager and utilizing electronic communication it shall be attended by: the CSB ES Director (or designee) associated with the Critical Event, the SWVMHI Facility Director (or designee), other regional CSB ES Directors (or designees). The ES Director reporting a Critical Event will also notify the Executive Director of their CSB, provide a copy of the Critical Event Reporting Form and invite to participate in the Post hoc meeting.

The Post hoc meetings will use the attached form to report on key elements of a Critical Event with the goal to identify any deviations from accepted protocols, evaluate for medical/legal/social complications and discuss the

extent that they influenced or created the Critical Event. The outcome shall be a consensus report to the larger QI Process group with recommendations for solutions. Other stakeholders may also receive recommendations for proposed solutions when appropriate. An example would be working with a local ER on resolving disagreements related to medical stability that resulted in a PAS extended past a ECOs time limit.

Suggestions for process modifications may be submitted by the QI Process group to the regions Regional Authorization Committee (CART), the SWVBHB, individual CSBs and state/private facilities. Suggestions related to adherence or deviation from established Regional Admission Protocols shall be vetted through the CART and addressed by any combination of the QI Process group as it most appropriate. Suggestions for QI outside of this Regional Admissions Protocol shall be reported to the SWVBHB for direction. These could include issues with judicial courts (Magistrates or Special Justices), intersection with private hospital system policies, etc.

As part of the Regional Admissions Protocol, this policy and procedure and associated forms will be updated as needed and agreed upon by the CART. Revision dates will be noted and any changes will be reported to the SWVBHB.

CRITICAL EVENT REPORTING FORM (CONFIDENTIAL: For Quality Improvement Process Only) ATTN: Project Manager; QI Process

Instructions: 1) This form must be completed when a CSB has an event such as: Pre-Admission Screening (PAS) exceeding ECO time limits, PAS's requiring state Facility Director Involvement, and PAS's resulting in failure to obtain a bed for persons requiring a TDO.

CLIENT NAME & CSB	DATE & TIME of EVENT:	Total Time for PAS:	OPEN:	OPEN:	OPEN:

Location of Assessment:
Hospital:_____

Other:_____

County/City:_____

TYPE OF CRITICAL EVENT:
☐ PAS exceeding an ECO time limits

☐ PAS required state Facility Director involvement.

☐ PAS resulting in failure to obtain a bed for persons requiring a TDO.

ECO? (includes paper & paperless)
☐ Yes
☐ No

Variance from Reg. Adm. Protocol?
☐ Yes
☐ No

DESCRIPTION of CRITICAL EVENT:
_____
_____
_____
_____
_____
_____
_____

OUTCOME FOR CLIENT
☐ Admitted: Y / N. Type: TDO / Medical / Other:_____
☐
☐ Remained in ED
☐ Community Supports Available & Implemented (Safety Plan Developed even though this was not the best outcome)
☐ Remain in Supportive Setting (nursing home, ALF, etc)
☐ No further intervention, against clinical advice (Client refused to participate in safety plan or accept any offered service)

OF PRIVATE HOSPITALS CONTACTED (include CSUs):_____

STATE FACILITY CONTACTED? Y N
Fac. Director/Admin Name:
_____

Follow-Up:
_____
_____
_____
_____
_____
_____
_____

Recommendations:
☐ None
☐ Educate/Correct staff
Specify:_____
☐ Educate/Correct facility, agency
Specify:_____
☐ Rec Change in Protocols
☐ Other: _____
_____

Designee for Follow-Up:
_____
Date:_____

Re-Visit Recommendations? Y / N
Date:_____
Designee:_____

Signature of ES Director:
_____
_____
_____
___
Date:___
_____

Executive Director Notified (incl. CE Reporting Form): Y / N

Fax completed form to Derek Burton, Project Manager. 1-276-223-1633 -OR-

Send as attachment in an ENCRYPTED e-mail to derek.burton@mrcsb.state.va.us

Attachment A

Guidance and Procedures for Medical Screening and Medical Assessment.

The purposes of the medical screening is to attempt to make sure that the individual is not experiencing a serious medical event that is masquerading as a psychiatric disorder or being concealed by a psychiatric disorder and that the receiving facility can provide the medical care the individual needs.

This procedure contains key elements that will be further detailed in the forthcoming "*DBHDS Medical Screening and Medical Assessment: Guidance Materials*," developed in joint fashion with the key stakeholders.

Psychiatric hospitals and units typically have fewer medical and medical nursing resources than hospital medical and surgical units. These free standing psychiatric hospitals and psychiatric units may lack access to immediate labs or other tests (especially on a STAT basis), have no electronic monitoring capability, may not be able to provide IV fluids or medications, and may have less clinical experience on hand at both the Nursing and Physician level.

Examples of conditions which typically cannot be managed safely in these psychiatric settings include acute delirium, head trauma, unstable fractures, unstable seizure disorders, active GI bleeding, bowel obstruction, acute respiratory distress, sepsis, overdoses, open wounds, surgical drains, severe burns, intracranial bleeds, pulmonary embolus, acute drug withdrawal with autonomic instability, active labor, major serum electrolyte abnormalities, and so forth.

A typical psychiatric unit can monitor vital signs non-invasively, provide oral medications, monitor fluid "input and output," monitor pulse oximetry intermittently, institute common preventative actions, and observe for signs of distress. Units that are part of general hospitals have more immediate access to emergency medical care, STAT labs and other tests, but typically no more capacity to provide more intensive medical treatment.

Preventative monitoring and management of some drug or alcohol withdrawals can typically be done. Pregnant patients (other than high risk), individuals with HIV, individuals with type I diabetes, individuals with PEG tube feedings, and those requiring a wheelchair can typically be managed safely. Physical therapy may be available. Nursing interventions to prevent decubitus ulcers, oropharyngeal aspiration, bowel obstruction, and transmission of most communicable diseases are generally possible.

During the Pre-Admission Screening (PAS), information will obtained on past and current medical illnesses and conditions, previous psychiatric hospitalizations and medical hospitalizations, psychoactive and other medications used, and substance use or dependence, including risk for intoxication and/or substance withdrawal. If an individual is already under care of a medical facility when the PAS is requested then EMTALA regulations governing screening, stabilization and transfer will apply. And in the event that transfer seems indicated from the PAS, then the treating physician and receiving facility will make the determination of medical stability and appropriateness of such.

Given the complexity of both human illness and health care systems, each case is to be reviewed with consideration of the individual's needs, the resources of the receiving facility and the resources of the local medical community. When medical conditions are assessed to determine if they are both stable and within the capabilities of a receiving facility, these decisions shall be rendered in a timely manner by both the sending and receiving facility. The prescreener will be responsible for notifying both the evaluating facility and receiving facility of elapsing time on the ECO.

Attachment B

Referral of Forensic Patients to the Central State Hospital Forensic Unit
(November 21, 2012)

This protocol is intended to provide guidance to state facilities regarding when forensic admissions should be considered for referral to the Central State Hospital (CSH) Forensic Unit. The presumption is that local civil beds are the default admission location except in more serious criminal cases. The following guidelines apply to persons admitted to DBHDS facilities pursuant to court orders for the following: pretrial evaluation (19.2-169.1 and 19.2-169.5); competency restoration (19.2-169.2); emergency treatment (19.2-169.6). The placement of persons adjudicated unrestorably incompetent (19.2-169.3) currently in jail or housed in the community and civilly committed, while rare, should generally be considered along the same general guidelines.
General Guidelines

1. If a patient is out on bond, but has pending legal charges and has been ordered for inpatient admission, from a risk perspective he/she should be treated like any other civil admission and should therefore be admitted to a civil hospital in the absence of extenuating circumstances.

2. If a patient is an insanity acquittee on conditional release, unless he/she is being revoked for serious/dangerous violations he/she should be admitted to a civil hospital (regardless of whether he/she was conditionally released straight from the maximum security unit at CSH).

3. The presence of a felony charge should not result in automatic referral to CSH. Each potential admission should be treated on a case-by-case basis with consideration of the following factors: current level of aggressiveness in jail, history of assaults/violence, history of violence during previous admissions to a state facility, significance of escape risk (facing long [10+ years] prison sentence), other/previous violent crimes, particularly heinous aspects of history/crime, and history of victimizing frail/mentally ill. Presumption is that defendants will be admitted to a civil hospital in the absence of significant behavioral and legal considerations.

The following is a list of charges which may lead to placement in the CSH Forensic Unit. The list is in no way exclusionary, and these charges should not automatically lead to CSH admission in every case. Please see the "Comments" section for each charge for additional guidance. Each admission must be decided on a case by case basis. For guidance regarding the admission of new insanity acquittees for temporary custody, please consult the *Guidelines for the Management of Persons Found Not Guilty by Reason of Insanity.*

Charge	Code Section	Comments
Murder	18.2-31, 18.2-33	Given the escape risk, individuals charged with murder will rarely be placed in a civil hospital, but it may be appropriate when the defendant is significantly impaired or incapacitated, and currently not aggressive.
Malicious Wounding	18.2-51	Less serious offenses may be admitted to a civil hospital, particularly if there is no

		other history of serious aggression and the person is not currently aggressive.
Escape from jail or correctional facility	53.1-203 18.2-477	If jailed on other offense, but has history of escape, then will likely need to go to CSH.
Kidnapping by Force	18.2-47	Individuals charged with abduction not involving physical aggression may be appropriate for civil hospital placement.
Rape, Sexual Assault,	18.2-67 18.2-61	Those charged with less serious sexual charges, but that involve preying on sick/vulnerable

REGION IV

Region IV Emergency Services Protocols (3/14/14)

Bed check lists

Region IV Emergency Services staff will utilize a combination of bed check lists and the Bed Registry to locate available beds in inpatient psychiatric hospitals, regional Crisis Stabilization Units and the State hospitals. Each CSB/BHA will also maintain a **current** list of all the Region IV contracted (Acute Care Project) facilities. Notes about calls to each facility may be maintained on the bed check list, bed registry site or noted directly on the prescreening supplement.

Since the Bed Registry system is new, the region may determine over time whether this system will replace the bed check lists, or whether the Registry will be used in addition to the bed check lists.

Admission to a state facility (CSH, CCCA, Piedmont)

1) Attempts are always made to first locate a local acute bed before considering the state facility.
2) Region IV ES clinicians are required to call the contracted hospitals* and confirm refusal to admit before seeking a state hospital bed.
3) Prior to the expiration of the 4 hour ECO period, and regardless of how many contracted hospitals have already refused admission, a call is made and the prescreening is faxed to notify the facility that a state hospital bed may be needed.
4) The bed search continues in the next two hours in case there is an available and appropriate bed at another contracted facility.
5) If no other ACP facility has an appropriate bed and the ECO period is ending (approaching 6 hours), arrangements are then made for state hospital admission, with acceptance at the facility pending medical clearance.

* All contracted hospitals within the region are contacted, but (as of 7/1/13) 4 of them are located outside the region: Rappahannock, Virginia Baptist (Centra), The Pavilion at Williamsburg Place and Riverside. Every contracted hospital within the region is called, in addition to any out-of-region contracted hospital(s) that are located within 2 hours of the individual's local CSB.

Special populations

If the person is under 18 years of age:

The Commonwealth Center for Children & Adolescents (CCCA) has developed its own Bed Management Plan, which is inserted into these protocols (see below).

If the person is 65 years and older:

Piedmont Geriatric Hospital (PGH) maintains one "safety net" bed and will consult with the ES worker about the appropriateness of a PGH admission when a local acute care bed is not available. Consultation may include referrals to potential community-based geriatric facilities not already contacted. PGH will only accept individuals who are medically cleared by a PGH physician. For more information, please refer to the "PGH Admission Referrals TDO Checklist" attached to these protocols.

If the person in crisis has an intellectual disability, the following two steps are routinely taken:

1. ID Director from the CSB serving the individual is called
2. Region IV REACH Program is contacted

If the person in crisis is deaf, the following steps are routinely taken:

Given that federal regulations require all hospitals to provide interpreter services as necessary, the Admission Protocol should be followed for individuals who are deaf or severely hard of hearing as for any other adult person. As mandated by State Code, the Virginia Department for the Deaf and Hard of Hearing maintains a directory of Qualified Interpreter Services and works to remove communication barriers. Under some circumstances, such an individual who uses ASL may be admitted to Western State Hospital from any region, though typically after being hospitalized within their primary region.

Other:

In general, ES workers, acute care providers, and state facility staff will continue to be responsive to the unique needs of the individual in crisis, which may include language or other communication barriers, physical limitations, etc., by providing appropriate support and interventions.

Communication

All regional procedures regarding state hospital admission are reviewed by DBHDS. Once finalized, they will be distributed to all CSB clinical directors, state facility representatives, regional leaders, ES managers and ES clinicians, including prn staff.

Region IV Acute Care Project Contracted Hospitals – FY2014

Hospital Information			
Contract	**Hospital**	**Address**	**Contact**
2013-AE-0015E	Bon Secours Richmond Community Hosp.	1500 N 28th Street Richmond VA 23223	Beverley Bell (804) 281-8531
2013-AE-0015D	Bon Secours St. Mary's Hospital	5801 Bremo Rd. Richmond	Beverley Bell (804) 281-8531
2013-AE-0015G	VCUHS	1200 E. Broad St Richmond	William Maixner (804) 828-1467
2013-AE-0015A	John Randolph Medical Center	411 W. Randolph St. Hopewell	Steven Dixon (804) 452-3839
2013-AE-0015K	Poplar Springs	350 Poplar Drive Petersburg	Malcolm Holley 804-733-6874
2013-AE-0015F	Chippenham & Johnston-Willis Hospitals, Inc.	7010 Jahnke Road Richmond	Jane O'Toole (804) 327-4038

2013-AE-0015L	Southside Regional Medical Center	200 Medical Park Blvd Petersburg, VA 23805	Ellen Buchanan (804) 765-5876
2013-AE-00015B	Southern Virginia Regional Medical Center	727 N. Main St. Emporia	Debra Hewitt (434) 348-4580
2013-AE-0015J	Riverside Behavioral Health Center	2244 Executive Drive Hampton	Ann Graham (757) 827-1001
2013-AE-0015C	The Pavillion at Williamsburg Place	5483 Mooretown Rd Williamsburg, Virginia 23188	Chris Ruble (800) 582-6066
2013-AE-0015I	Centra VA Baptist Hospital	3300 Rivermont Ave Lynchburg VA 24503	Virginia Evans (434) 200-4705
2013-AE-0015H	Rappahannock General Hospital	101 Harris Drive PO Box 1449 Kilmarnock, VA 22482	Brian Clemmons (804) 725-6328

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS

Bed Management Plan

2/3/14

DBHDS maintains only 48 acute inpatient psychiatric hospital beds for Virginians who are under 18 years of age. These beds are at the Commonwealth Center for Children & Adolescents (CCCA) in Stanton, which serves the entire commonwealth. With this 48-bed limit, CCCA and its community partners, including private hospitals, juvenile detention and correctional centers, and community services boards (CSBs), have been successful in meeting all emergency hospitalization needs utilizing the plan below.

CCCA serves as the safety net for children and adolescents who require acute inpatient psychiatric care and cannot be admitted to or remain in any other child/adolescent psychiatric hospital in Virginia. All valid referrals are accepted for admission assuming adequate exploration of alternative placements, medical clearance, and available bed space. To date the system has been able to meet the emergency placement needs of all children and adolescents through appropriate diversions and bed management at CCCA through discharge planning.

Unlike the eight regional DBHDS psychiatric hospitals serving adults, CCCA does not have a back-up hospital within the system to accept patients if full. This, along with a high volume of admissions and a short average length of stay, intensifies the need for active and effective bed management at the facility and community levels. In addition to the steps taken by CCCA and community partners related to admissions and discharges described below, it is of course the case that adequate support for community-based crisis management services, as well as those services providing pre-crisis interventions, will both prevent hospitalizations that would otherwise be necessary and aid in more rapid discharges, thus preserving space at CCCA for necessary admissions and maximizing the number of children and adolescents who can be served close to home.

Admissions Process

- CCCA accepts referrals of young people up to 18 years of age who are in need of inpatient psychiatric hospitalization from the entire Commonwealth
- Our Intake/Admissions Office is staffed 24 hours a day, 7 days a week, and we accept admissions 24 hours a day, 7 days a week (540-332-2120)
- Other than admissions ordered pursuant to VA§ 16.1-275 or 16.1-356 (court-ordered evaluations), all admissions must first be prescreened by a CSB
- Any calls not from CSBs (other than in cases of VA§ 16.1-275, in which we still request though cannot require a CSB prescreen), are referred to the CSB for appropriate pre-admission prescreening
- Our Intake/Admission Specialist consults in every referred case with the CSB Emergency Services Prescreener to
    - Gather information about the reasons hospitalization is being considered and alternatives that have been tried and that may be available
    - Reviews all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act
    - Consider the need for hospitalization, and if hospitalization is needed the availability of other options, particularly those that keep the child or adolescent close to home
- While the Intake/Admission Specialist may encourage the prescreener to explore options not considered, including providing names of alternative hospitals, we will accept any child/adolescent who is ultimately determined by the CSB to need emergency hospitalization and has no other option
- There is no minimum number of other hospitals that must be called; admission elsewhere will be encouraged if possible, with greater emphasis if the child/adolescent is from far away and/or we have fewer available beds
- The Uniform Prescreening Report must be received prior to acceptance for admission
- If there are active medical issues, the Intake/Admission Specialist will consult with our on-call physician to determine if medical clearance is necessary
- The specific process (method of transport, ways of obtaining consent, etc.) is dependent on the type of admission (e.g., Voluntary, Involuntary, Objecting Minor, TDO) and the specific needs of the child/family
- In cases in which we believe an admission to be inappropriate, we may exert considerable pressure on the community to identify alternatives. Assuring the appropriateness of admissions serves to prevent unnecessary and possibly distressing separation of the child/adolescent from his/her community, avoid unnecessary resource utilization, and maintain available bed space for appropriate admissions

Bed Management

A. Diversion

The only time CCCA would defer a valid admission is if it is at or very near capacity. Because the 48 beds are the only public acute psychiatric beds for the entire Commonwealth, and because admissions are unpredictable and may be heavy (e.g., 20 or more admissions in a week or 5 or more admissions in a day) there are times when capacity becomes an issue. When we are near or at capacity, we

- Contact CSB Emergency Services Departments and inform them, noting our available beds at the time and requesting that they divert if at all possible,
- Forensic admission referrals for Court Ordered Evaluation pursuant to §16.1-275 of the Code of Virginia will be placed on the CCCA Waiting List and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Court Ordered Evaluations are ordered for children not in psychiatric crisis, but for whom an evaluation of treatment needs is warranted. These children are most often in detention centers and therefore in a safe place to await admission to CCCA.
- Forensic admission referrals for Evaluation of Competency to Stand Trial pursuant to §16.1-356 will be placed on the CCCA Waiting List and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Such children are in juvenile detention centers or in the community as determined appropriate by a judge and will remain in that setting to await admission.
- When no bed space is available at CCCA for emergency civil voluntary or involuntary admissions meeting criteria per the Code of Virginia who have been prescreened and found to be appropriate for admission by a CSB, attempts will be made to implement a crisis/safety management plan and maintain the child in the community or in the present placement until bed space at CCCA is available
- If these diversionary strategies are not possible, attempts will be made to divert the child to a private inpatient facility utilizing TDO admission, Medicaid, or other third party means.
- Consider refusing admission for patients who are in a safe place (e.g., another facility or detention) until space becomes available
- If diversion attempts are not successful, child will be placed on a waiting list for admission to CCCA. CCCA waiting lists will be prioritized in consultation with CSB referral staff, taking into account acuity of the situation and safety of the child.

B. Discharge

The availability of beds for admission is dependent on patients being discharged when clinically appropriate. Clinical teams always work closely with families and communities to facilitate timely discharge, working together to manage challenges that include delays before desired community-based resources become available or the absence of such resources, differences of opinion about clinical readiness for discharge or discharge placement options, transportation availability, etc. When CCCA nears capacity, we also

- Encourage families and communities to rapidly identify and develop discharge options and support plans
- Discharge any patients who may be safely discharged but remain in the hospital based on clinical discretion

PIEDMONT GERIATRIC HOSPITAL
Needed Medical Information for a TDO Admission

Brief Description of Piedmont Geriatric Hospital:

PGH is a 135-bed, freestanding, psychiatric facility. It has limited medical care capability for acute cases that require immediate laboratory, x-ray, or other diagnostic tests. To maximize patient safety, we encourage stabilization of acute medical problems prior to admission.

TDO Admission to PGH:

The TDO process requires admission candidate screening by CSB (Community Service Board) Emergency Services staff to determine that the individual suffers from mental illness requiring inpatient care and that there is no less restrictive alternative available. Once it is determined that a bed is available, the next step is to determine medical clearance as required by DMHMRSAS Instruction 101.

The CSB is requested to fully complete the Uniform Pre-admission Screening form to include:

--all medications (including psychotropics)
--known allergies

If the individual is known to the CSB or if there are available records from a community living situation, please forward the most recent psychiatric evaluations, and general treatment information. Please ensure that family/emergency contact persons are made aware of the pending admission to Piedmont and provide contact information to PGH staff.

If individual on TDO is not committed at the hearing, CSB staff are expected to facilitate appropriate discharge.

Medical Clearance:

Behavioral symptoms such as confusion, agitation, and aggression are frequently caused by acute medical problems in the geriatric population. This is particularly probable in persons who have no previous psychiatric history. Frequent causes of acute delirium in the elderly include: pneumonia, urinary tract infection, dehydration, organ failure, and CVA. These individuals are best served in an acute care facility prior to referral to PGH. **To rule out medically induced psychiatric symptoms, the following are essential:**

--Physical examination
--CBC
--Urinalysis
--Comprehensive Metabolic Panel (Chem. 20)
--EKG
--Chest X-ray

The following tests are recommended, based on the physician's assessment:

-CT Scan and MRI of the head, as clinically appropriate
-Urine drug screen & Blood alcohol level, if clinically indicated
-Cardiac enzymes, based on the individual's medical history and current cardiac condition

A member of our medical staff is on call to consult with ER, Hospital, and Community Physicians regarding any issues/problems identified. Please contact us early in the process so we may assist in expediting the screening process.

To contact the Admissions Clinician call (434)294-0112; Fax (434)767-2352 from 7:30 a.m. to 4:00 p.m. weekdays.
After 4 p.m., weekends, or holidays, call (434)767-4401; Fax number will be designated by Admissions Clinician.

REGION IV REINVESTMENT PROJECT

ACUTE CARE PROJECT

SERVICE DESCRIPTION & ADMISSION PROCEDURES

Updated 03/14/2014

DESCRIPTION: The Region IV Acute Care Project ("the project") provides an alternative to Acute Care treatment in the state hospital by establishing regional contracts for Acute Psychiatric Inpatient Services for Adults with private hospitals that are willing and able to deliver that service in collaboration with partner Community Services Boards (CSBs/BHA). On behalf of the Department of Behavioral Health and Developmental Services (DBHDS) and in accordance with the *Code of Virginia,* as amended, the local CSBs/BHA serve as the sole "gatekeepers" for admissions to Central State Hospital and qualified local private hospitals.

By statute, CSBs/BHA are required to pre-screen all potential admissions and recommend hospitalization only for those persons who meet inpatient psychiatric commitment criteria and for whom less restrictive community-based options are not appropriate. In addition, CSB/BHA staff and hospital staff are required to work jointly upon admission to develop treatment plans and ensure appropriate hospital services. CSBs/BHA, in collaboration with hospital staff, are responsible for pre-discharge planning, which must begin at admission.

In effect, CSB/BHA staff function as members of the hospital treatment team and can participate fully in all diagnostic staffing, treatment planning conferences, continuing case conferences and reviews, discharge planning conferences, and other hospital-based inter-disciplinary activities.

SERVICE GOAL: To ensure that uninsured individuals have access to appropriate care and treatment in a local psychiatric hospital in order to divert from a state inpatient hospitalization. To minimize an individual's length of stay by providing active utilization management during his/her course of care.

AGE GROUP: Adults, ages 18-64, inclusive.

GENDER: Eligibility for this project shall not be determined on the basis of gender.

FREQUENCY: Daily.

LENGTH OF STAY: Variable. Average LOS for project-funded individuals is 6 days.

PROJECT FUNDING ELIGIBILITY: Limited acute care project funding is available to adults in Region IV, who fit the following criteria:

- Meet inpatient psychiatric hospitalization criteria; and,
- Hospital admission is being initiated by the individual's CSB case manager or Emergency Services department staff; and,
- Have no other means of payment to fund their hospitalization; and
- Reside or experience a psychiatric emergency while in a catchment area served by a Region IV CSB/BHA.

RULE OUT (*not eligible for project funding; these are examples and not necessarily all-inclusive)*:

- Individuals who seek psychiatric treatment and are voluntarily admitted to a local hospital without contacting anyone at the CSB.
- Individuals who are receiving services from a CSB in another region (*Admitting CSB should contact out-of-region CSB and inquire about that region's LIPOS funding the individual)*.
- Individuals who receive ongoing psychiatric treatment from a private provider, and/or are hospitalized under the care of his/her private provider, and who intend to continue receiving services from that private provider upon discharge (even in the event of a TDO).
- Individuals who have Medicaid or other private insurance, even if benefits are exhausted during his/her acute care stay.

Possible Exceptions:

- For an individual who is actively enrolled in services with a Region IV CSB: when s/he seeks psychiatric treatment and is voluntarily admitted, or if/when a TDO is later sought, the CSB has the authority to consider project funding after conducting a prescreening.
- For an individual with Medicaid: When there is no available bed at a Medicaid-accepting facility but there is a bed in a facility that does not accept Medicaid, the CSB has the authority to consider project funding if it means diverting the individual from CSH.
- For an individual with insurance that has been exhausted: If that individual is approved by the Regional Admissions Committee (RAC) for transfer to Central State Hospital (CSH), RAC may approve project funding from the date of approval to the date of transfer to CSH.
- For individuals receiving private psychiatric treatment and who are hospitalized under a TDO: the CSB may approve project funding if it means diverting the individual from CSH.

*****Any requests for project admission that are other than routine must be considered prospectively by RAC and may be approved for funding.***

SERVICE ALTERNATIVES:

Out of region/non-contractual hospital, when Region IV contract hospitals are not available to meet individual need for acute care (with Regional Manager approval).

State hospital TDO admission (per Region IV "safety net" protocols dated March 14, 2014).

DISPOSITION

CONTINUED CARE: The CSB representative (CM, ES) has f/f contact with the individual in the acute care facility and determines that more than 5 days (but less than 10) of project-funded inpatient care is required to stabilize the individual.

When a project-funded inpatient admission exceeds 5 days (of funding), the Region IV UM staff will present the case to RAC to authorize continued funding beyond 10 days. Cases will be reviewed and authorized by RAC at least weekly until discharge or transfer.

LESSER CARE/DISCHARGE:

- Individual no longer requires acute treatment in a locked unit and can voluntarily consent to be "stepped down" to a crisis stabilization unit.
- Individual no longer requires this level of care and is discharged from the acute care facility.
- The CSB withdraws funding (i.e. individual no longer receiving active treatment).
- RAC withdraws funding (i.e. individual no longer receiving active treatment).

Note: The day of discharge/withdraw is not counted in the total funded days. If an individual is transferred from a psychiatric unit to a medical unit, funding is withdrawn the day of transfer. Funding may be reinstated upon readmission to the psychiatric unit.

HIGHER CARE/TERMINATION: Any individual who is not responding to treatment, regardless of who is paying for their stay, can be referred for long-term treatment at a state psychiatric facility. The treating acute care facility must make a referral to the CSB and request an assessment and RAC review.

TYPE AND ROLE OF STAFF:

- CSB case management and emergency services staff to conduct preadmission screenings, locate beds, authorize project funding, collaborate with hospital staff, monitor individual's progress in treatment, assist with discharge planning. Coordinate with hospital, Regional UM staff, RAC, and CSH to facilitate transfer to state hospital.
- RAC to conduct reviews of all cases, authorize continuing services, consider individuals for transfer to the state facility. RAC is comprised of director-level staff from CSBs/BHA and CSH, as designated by the Region IV consortium.
- Region IV Utilization Management staff to review, monitor and report on requests for project funding. Beginning with notification of project admission, conduct active review of cases.

CONTRACTUAL SERVICES: Qualified local private hospitals will provide these services through Contractual arrangements with the Richmond Behavioral Health Authority (RBHA). Any of the participating Consortium CSBs/BHA may utilize any of the established Contracts.

Region IV CSBs/BHA able to access project funds for individuals include: Chesterfield, Crossroads, District 19, Goochland-Powhatan, Hanover, Henrico Area, RBHA.

When a Region IV CSB/BHA staff determines that an individual meets the criteria for Acute Care Project Funding (see Service Description above), the Project Admission process begins.

ADMISSION PROCESS

Responsible Person/Situation	Activity
CSB/BHA Case Manager or Emergency Services Staff/Once individual is admitted to the hospital.	**Completes** the *Project Admission Form*, and **notifies** Regional UM staff of the admission. **Faxes** the *Form* to both the Regional UM staff contact and the Region IV office within 48 hours of the individual's admission or the day after the commitment hearing. **Communicates** to the hospital that project funding has been initiated for no more than 5 days. **Authorizes** the funding start date per *Funding Initiation Table* below (with the exception of hearing delays, i.e. due to weather). **Meets** with individual face-to-face within 48 hours (2 working days) of admission to hospital (in event f/f did not occur at the time of admission). **Conducts and documents in the clinical chart** follow-up on clinical status of individual at least every <u>two</u> working days throughout admission. **Completes** *Project Discharge Form* at discharge and submits to both regional UM staff and regional office.
CSB/BHA Case Manager or Emergency Services Staff/Individual requires more than 5 days (but less than 10) of project funding.	**Reassesses** the individual f/f and determine need for continued inpatient treatment. **Documents** assessment and attaches to *Project Authorization Form* requesting up to 5 additional days of project funding. **Submits** the updated *Form* to regional UM

	staff and regional office.
CSB/BHA Case Manager or Emergency Services Staff/Individual requires more than 10 days of project funding.	**Notifies** Regional UM staff when an individual's hospital stay reaches 7 days or when discharge plan is uncertain. **Prepares and submits** to Regional UM staff written documentation re: individual's active treatment, estimated LOS, and discharge plans.
Regional UM Staff/Individual's hospital stay approaching 10 days and/or discharge plan uncertain.	**Conducts** f/f meeting with individual, reviews hospital and CSB/BHA documentation prior to next RAC meeting. **Presents** individual case to RAC at next scheduled meeting. **Performs** active UR until individual is discharged from hospital (to include transfer to state facility. *See RAC Admission Procedures*).
Regional Authorization Committee	**Considers** all requests for extended funding, specialized services (funding for), requests for transfers to state facility. **Authorizes** continued funding, specialized funding, continued review of individual's case until individual is discharged from hospital or transferred to state facility. *See RAC Admission Request Procedures.*) **Documents d**etermination on *Region IV RAC Form*.

Note: Procedures may be modified when project funding is scarce.

REGION IV STAFF CONTACT INFORMATION:

Karen E. Marsh, RN, BS, MPA (**UM Staff)**
804-338-3602
804-748-5981 (Fax)
marshk@rbha.org

Maria L. Baker, LCSW
(UM Staff)
804-240-7029
804-590-1359 (Fax)
bakerm@rbha.org

Amy Erb, MSW
Director Regional Programs,
804-819-4187 (Office)
804-690-0932 (Cell)
erba@rbha.org

FUNDING INITIATION TABLE: Excluding court closings, the list below outlines what DMAS is paying and when Project Admissions occur. Any days the courts are closed or the Special Justices do not hold hearings, the start day would shift to the next day.

Monday TDOs DMAS pays Mon/Tues (Pays day of hearing Tues) - grant starts Wed

Tuesday TDOs DMAS pays Tues/Wed (Pays day of hearing Wed) - grant starts Thurs

Wednesday TDOs DMAS pays Wed/ Thurs (Pays day of hearing Thurs) - grant starts Friday

Thursday TDOs DMAS pays Thurs/Fri (Pays day of hearing Fri) – grant starts Saturday

Friday TDOs DMAS pays Fri/Sat/Sun (DOES NOT PAY day of hearing) - grant starts Mon

Saturday TDOs DMAS pays Sat/Sun (DOES NOT PAY day of hearing) - grant starts Mon

Sunday TDOs DMAS pays Sun/Mon (Pays day of hearing Mon) - grant starts Tues

In the event a hearing is conducted on the day of the hospital admission (day of the TDO) the grant would start the next day.

Region IV Acute Care Project **Project**

Admission and Payment Authorization(s)

WITH: Hospital/facility: _____ Date: _____ Authorizing CSB/BHA: _____

AND: Treating Psychiatrist: _____ Hospital Admission Date: _____

AND: *Client:* _____ *DOB:* _____ *Age:* _____ *Gender: M/F*

Social .Security Number or Client ID #: _____

DX(s): (Axis I) _____ Code(s): _____

(Axis II) _____ Code(s): _____

(Axis III) _____ Code(s): _____

(Axis IV) _____ Code(s): _____

(Axis V) _____ Code(s): _____

Project Admission Date: _____ **Number of Days Authorized**: _____

Type of Admission: [ ]Voluntary [ ] Pursuant to TDO [ ]Court Mandated Voluntary [ ]Involuntary Commitment

Is this client receiving services from the CSB/BHA prior to the time of admission? [ ] Yes [ ] No

Initial Authorization not to exceed 5 Days – Extensions require approval of participating CSB/Authority

The client identified above is being referred to your facility for acute psychiatric in-patient treatment. Payment will be made by the referring Community Services Board / Behavioral Health Authority as per the Regional Agreement and Region IV Consortium Bed Purchase Contract. This contract includes per diem rates for psychiatric care and in-patient psychiatric services. Any other charges, including those for non-psychiatric medical problems, are specifically excluded. Services are not billable to the client under the contract. The referring Community Services Board/Behavioral Health Authority shall determine the client's eligibility for extended admission under the project. **Extensions/reauthorizations are not to exceed 5 days. Extensions beyond day 5 require a face to face assessment and a brief narrative note indicating reason for continued hospital stay. Requests beyond 10 days require a RAC review and authorization.**

CSB/BHA Project CM: _____Telephone: _____ Pager/Cell: _____

Project Admission Approval: CSB/BHA Authorizing Representative: _____

(Signature)

Reauthorization Date: _____ Reauthorization Terminates on: _____(date)

Project Reauthorization Approval CSB/BHA Authorizing Representative: _____

(Signature)

Reauthorization Date: _____ Reauthorization Terminates on: _____(date)

Project Reauthorization Approval CSB/BHA Authorizing Representative: _____

(Signature)

Reauthorization Date: _____ Reauthorization Terminates on: _____(date)

Project Reauthorization Approval CSB/BHA Authorizing Representative: _____

(Signature)

Reauthorization Date: _____ Reauthorization Terminates on: _____(date)

Project Reauthorization Approval CSB/BHA Authorizing Representative:

_____

(Signature)

Reauthorization Date: _____ Reauthorization Terminates on: _____(date)

Project Reauthorization Approval CSB/BHA Authorizing Representative:

_____

(Signature)

APPENDIX A – 2/2010 Copy to: CSB/BHA Admitting Hospital Regional Authorization Committee c/o John Lindstrom RBHA

FAX: 804-819-4265

Region IV Acute Care Project
Project Discharge [ ] Withdrawn from Project [ ]

Local Hospital/facility**:** _____ Date: _____
CSB/BHA: _____
***AND**: Client:* _____ *Soc Security or Client ID #:* _____
Project Discharge/Withdrawal Date: _____ *Total Continuous Project Days:* _____
Reason for Project Withdrawal (if applicable):
_____

Acute Care related authorizations: Transportation:
_____
Other
_____
Diagnosis at Time of Discharge:
(Axis I) _____ Code (s) :_____
(Axis II) _____ Code (s) :_____
(Axis III) _____ Code (s) :_____
(Axis IV) _____ Code (s) :_____
(Axis V) _____ Code (s) :_____

Clinical Status at Discharge: *(check all that apply)*
□ *Pre-hospital symptoms are reduced / resolved; and/or returned to pre-hospital condition.*
□ *Able to follow treatment plan in the discharge setting.*
□ *Aggression/threatening behavior reduced or resolved.*
□ *Able to adhere to pharmacologic plan in the new setting.*
□ *New symptoms emerge needing another treatment setting.*
□ *Symptoms persist requiring rehabilitation.*
□ ***Willing to seek outpatient treatment.***
□ ***Client is detoxified.***

Ongoing Follow-up / Treatment Arrangements:

Housing
□ *Family/Friend/Private* □ *Supportive Apartment* □ *ALF* □ *Shelter*
□ *Boarding House/Rooming House* □ *Other(Please Specify)*_____

Psychiatric Services
□ *CSB Psychiatrist* □ *VAMC* □ *Private Psychiatrist*
□ *Primary Care Physician* □ *Other(Please Specify)* _____

Case Management

☐ *SMI/Mental Health* ☐ *Mental Retardation* ☐ *ICT*
☐ *PACT*
☐ *Substance Abuse* ☐ *Other(Please Specify)* _____

Outpatient Services

☐ *Therapy* ☐ *Substance Abuse* ☐ *Partial Hospital*
☐ *Vocational* ☐ *Psychosocial Day* ☐ *Residential/MHS*
☐ *None* ☐ *Other (Please Specify)* _____

Alternative Services

☐ *Jail/Corrections* ☐ *Discharge AMA*
☐ *Nursing Home* ☐ *Medical Facility*_____

Are on-going services planned? ☐ Yes ☐ No

If not planned, why not: ☐ Other provider ☐ Non-resident ☐ Refused
☐ Other _____

□ *CSB/BHA:* *Date of appointment:* _____
□ *Referral to another Agency:* *Date of appointment:* _____
□ *Transfer to another provider, locality or setting:*
_____
□ *Other arrangement / actions:*
_____

Project Discharge / Transfer Approval CSB/BHA Representative: _____

(Signature)

Region IV: Regional Authorization Committee

c/o Kelly Furgurson RBHA Fax: 804-819-4268

Date: _____

To: CSB:_____ Case Manager:_____

From: Kelly Furgurson, LPC

Region IV: Regional Authorization Committee Chairman

Re: _____

Hospital: _____ Admission Date:_____

Project Funding Initiated: _____ Day #: _____

Today the Regional Authorization Committee reviewed your

[ ] Request for transfer to CSH

[ ] 10 day continued stay request

[ ] Other: _____

The following action(s) was taken

[ ] Request for transfer to CSH was approved pending
[ ] Bed availability
[ ] Continued Medical Necessity – we will review the case again next week
[ ] Your request for transfer was approved and you will be notified as to a date of transfer by CSH staff
[ ] Your request for transfer was approved and project funding has been authorized.
[ ] Your request for transfer will be continued – continue community hospitalization and provide additional information as outlined below – we will review the case again next week
[ ] Your request for transfer will be continued – continue community hospitalization and we will review the case again next week
[ ] Your request for transfer has been denied
[ ] Your continued stay request has been approved
[ ] Other: _____

The following suggestions/recommendations were made:

_____
_____
_____
_____
_____
_____

REGION IV REGIONAL AUTHORIZATION COMMITTEE

CENTRAL STATE HOSPITAL

ADMISSION REQUEST PROCEDURES

Updated 3/14/2014

PURPOSE:

When an individual receiving local inpatient care does not respond favorably to interventions after a 14-21 day period of active acute care treatment and the treating physician feels that the consumer would benefit from long term treatment at a state facility, a request for a RAC review is made to the jurisdictional CSB. Adults ages 18-64, inclusive, may be referred to the Region IV Regional Authorization Committee (RAC) for consideration for admission to Central State Hospital, regardless of who is paying for the individual's stay.

Note: Adults aged 65 and older, requiring long-term care in a state facility, are to be referred directly to Piedmont Geriatric Hospital (PGH). Brief admission procedures for PGH are included at the end of this document.

These procedures apply to the following Region IV CSBs/BHA: Chesterfield, Crossroads, District 19, Goochland-Powhatan, Hanover, Henrico Area, and Richmond Behavioral Health Authority.

ROLE OF RAC:

The Regional Authorization Committee (RAC) is charged with maintaining a functional census in Region IV's state hospital (Central State Hospital), which has a limited number of available beds. RAC also reviews the clinical progress of individuals served throughout Region IV's community hospitals and attempts to transfer those who are not responding to treatment in the community setting. Transfer to CSH is dependent not only on the consumer's clinical need but also on bed availability.

The RAC is comprised of members from those CSBs/BHA that have high utilization of CSH beds and Acute Care Project funds (Chesterfield, District 19, Henrico Area and RBHA). In addition, representatives from CSH serve on the committee, along with the Region IV Program Director and UM staff. The RAC typically meets every Thursday at 1:00 pm at CSH.

Request for transfer procedures are outlined below, assigning tasks to specific responsible persons or entities.

Responsible Person/Situation	Activity
CSB/BHA Case Manager or Emergency Services Staff and/or Acute Care Facility/Individual is assessed as requiring long-term care in a state psychiatric facility.	**Alerts** Regional UM staff that a Request for Transfer is going to be made and coordinates with UM staff in advance of next-scheduled RAC meeting.
Acute Care Facility/Attending Physician	**Prepares** letter of request, **submits** it to the CSB/BHA, and places it in individual's clinical chart in advance of scheduled RAC.
CSB/BHA Case Manager or Emergency Services Staff	**Meets** f/f with individual and documents determination that request for transfer is warranted. **Confirms** with Regional UM staff that CSB is in agreement with the request for transfer. **Prepares** summary of individual's psychiatric history and current status using regional *Case Presentation Format*. *(Note: if individual is voluntary patient, then s/he must be in agreement with transfer and be certified by two psychiatrists that s/he has the capacity to make that decision)* **Forwards** all documentation to UM staff in advance of the scheduled RAC meeting.
Regional UM Staff/Preparation for RAC presentation.	**Coordinates** and liaises between all parties; reviews medical record; conducts f/f assessment of individual; confers with hospital and CSB staff. **Prepares** record for RAC review and schedules RAC presentation/review.
Acute Care Facility/Attending Physician	**Provides** copy of individual's acute care treatment record to UM staff approximately 3-5 days in advance of scheduled RAC.

CSB Case Manager or Emergency Services Staff/RAC presentation	**Presents** individual to RAC in person at assigned date/time and provides copies of *Case Presentation* for all members of RAC.
Regional Authorization Committee	**Considers** clinical information presented and makes determination for transfer; decline transfer; or continued review based on admission criteria and current census. **Completes** *Communication Form* documenting outcome and prescribing next steps to CSB and/or facility.
CSB Case Manager or Emergency Services Staff/Individual approved for transfer to CSH.	**Notifies** acute care facility of RAC decision and requests appropriate records to be sent in advance of transfer date. **Coordinates** actual transfer with CSH Director of Social Work. **Ensures** commitment order will remain active through the date of transfer to CSH, reflects CSH or CSB designated facility, and transportation checked by special justice.
Central State Hospital/Social Work Director or Designee	**Schedules** date of admission for individual and coordinates with CSB and acute care facility on transfer. **Prioritizes** admissions when multiple admissions scheduled for the same week.

When the civil census is at 95 percent or higher of total capacity, discharges shall be effected in order of priority within 48 hours in order to return CSH's civil census to the 95 percent level.

TDOs to CSH: Though the goal of the region is to have no acute care admissions to CSH, there are circumstances that necessitate this process. It is expected that this measure is temporary until the individual can be transferred to a local hospital. To accomplish this goal, CSBs are to be diligent in pursuing a community-based facility, preferably within 24 hours, even if there has been a commitment order. If, for whatever reason, the CSB believes that CSH is a clinically-appropriate setting for a consumer, the CSB is to follow procedures outlined above.

Contact Information

Karen E. Marsh, RN, BS, MPA (UM Staff)
804-338-3602
804-748-5981 (Fax)
marshk@rbha.org

Maria L. Baker, LCSW
(UM Staff)
804-240-7029
804-590-1359 (Fax)
bakerm@rbha.org

Amy Erb, MSW
Director Regional Programs,
804-819-4187 (Office)
804-690-0932 (Cell)
erba@rbha.org

Ruth Ann Bates, MSW,
Social Work Director
Central State Hospital
804-524-7311
RuthAnn.Bates@dbhds.virginia.gov

RAC Case Presentation Format

Information in the first two sections should be given directly and without interruption by members of the RAC. These two sections should not take more than 5 minutes to present.

I. Identifying Client Background Data

Name:

Age:

Ethnicity and Gender:

Marital Status:

Employment Status:

Referral Source:

Name of Hospital:

Date of Admission:

What does the client state as what they want?

Give a brief explanation for each dimension below with estimated level of concern – High, Medium, Low. Use behavior descriptors (what might appear on a videotape) rather than diagnoses or symptoms, e.g., "looks off into corner of room and smiles" rather than "responds to internal stimuli."

II. Current Need for Placement by Dimension:

1. Acute intoxication/withdrawal potential:
2. Biomedical conditions and complications:
3. Emotional/behavioral/cognitive conditions and complications:
4. Readiness to Change:
5. Relapse potential (substance and/or mental health)
6. Recovery environment

The questions below will be discussed as a group. Please consider your responses before coming to RAC.

III. What problem(s) with High and Medium severity rating are of greatest concern at this time?

What about these problem areas are creating the need for long term care in Central State/Piedmont?

What would be the behavioral goals that would be accomplished through long term care?

What interventions (medication, living arrangements, etc.) have worked in the past (if know)?

What community resources would be needed, but are not available to effect a safe, least intrusive level of service for this person?

PIEDMONT GERIATRIC HOSPITAL

ADMISSION REQUEST PROCEDURES

Updated 3/14/2014

PURPOSE:

Adults aged 65 and older, requiring long-term care in a state facility, are to be referred directly to Piedmont Geriatric Hospital (PGH). Brief admission procedures are provided below and include the Checklist for Admission Referrals.

Guidance for admitting a TDO to PGH are found under the regional ES protocols dated 3/14/14.

ADMISSION PROCESS:

Step 1. Endorsement and referral.

- Acute care facility case manager requests CSB guidance for referral to PGH
- Emergency Services staff at the case managing CSB assesses whether the individual is appropriate for the long term psychiatric care provided by PGH; if so, the ES worker calls the PGH Admissions Coordinator to "endorse" the referral
- Acute care facility assembles and provides the information requested in the "Checklist for Admission Referrals" (attached), typically via fax to the Admissions Coordinator

  PGH's Admissions Coordinator (AC) is available to the acute care facility staff and CSB throughout the referral, as follows:

  - **Acute care facilities may call the AC for consultation or problem-solving before calling the CSB**
  - **The AC may facilitate a case review even if some information from the checklist is missing (i.e. an individual is refusing a specific test).** ***Note: the head CT/MRI is not mandatory for PGH's initial review***

Step 2. Review: Medical clearance and psychiatric assessment.

- PGH admissions physicians (physical medicine and psychiatry) review the referral package
- If a physician needs additional information, the PGH AC follows up with the acute care facility and/or ES worker, as needed
- Decision:
  1. If the individual is assessed as appropriate, then the transfer occurs (Step 3).
  2. If the individual is assessed as not appropriate, the AC follows up with the acute care facility and ES worker.

Step 3. Transfer (of appropriate referrals)

- The AC works primarily with the acute care facility on all aspects of the transfer, including: mutually-agreed upon schedule, transportation, updated legal documents, and the facility's transfer documentation.
- CSB ES supports, when necessary.

PIEDMONT GERIATRIC HOSPITAL
Checklist for Admission Referrals

CSB INFORMATION	☐ CSB Prescreening, with written update if over 10 days; phone contact with PGH admission worker ☐ CSB to provide contact notes, diagnostic and treatment information from CSB records
	Home CSB endorsement is required for PGH referral/admission.

HOSPITAL INFORMATION

PGH is a free standing psychiatric facility with the capacity to provide basic medical care. To maximize patient safety, a PGH physician must review information and accept patient for admission. Please provide the following information:

☐ History and Physical, including systems review and diagnoses

☐ Psychiatric Evaluation and diagnoses

☐ Current medications and treatments

☐ Current Lab Test Results: CBC, Comprehensive Metabolic Panel, Urinalysis, alcohol and drug screen, and others as appropriate to patient's medical condition and history.

☐ Chest X-ray

☐ EKG

☐ Head CT/MRI, other diagnostic tests as appropriate

☐ Physician and Nursing Progress Notes (last 7-10 days), including vital signs, eating and ambulation patterns, any special needs, skin breakdowns, medical devices, and implants

☐ **Physician to physician contact is required by CMS/Medicare**

☐ Face Sheet and contact information

☐ Commitment and Prescreening forms

If available/applicable:

☐ Legal documents (DNR, Power of Attorney, Advance Directive, Guardianship, other)

☐ Social History

☐ Discharge Summaries

☐ Rehab Services Assessments and Treatments

☐ PPD, Flu, pneumovax information history

Admission referral information will be accepted
from 8:15 AM - 5:00 PM Monday-Friday (except holidays)
Phone (434) 294-0112; Fax (434)767-2352
Patient admission hours: 8:30 AM – 2:00 PM Monday – Friday

Southside Behavioral Health Consortium - Region VI

Protocols for Admissions to Southern Virginia Mental Health Institute
March 10, 2014

Purpose

Southern Virginia Mental Health Institute (SVMHI) is a seventy-two-bed psychiatric inpatient treatment facility of the Commonwealth of Virginia. SVMHI admits individuals served by Piedmont Community Services (PCS), Danville-Pittsylvania Community Services (DPCS), Southside Community Services and Charlotte County (Crossroads Community Services).

Being a public facility of the Commonwealth of Virginia, it is an explicit role for SVMHI to serve as a "safety net" for those in need of inpatient care to ensure a safe, secure and caring environment by which individuals might receive swift and clinically appropriate interventions when no lesser level of care sufficient to the degree of need or when no private care resources are available. This document will disclose specific criteria for admissions, specific procedures and roles for the varying types of admissions and will also provide procedures to follow when the SVMHI's certified bed census is at 48 or above and an individual is in need of state inpatient psychiatric care.

The partnership between Community Services Boards, private providers of care and services, advocacy groups and SVMHI has provided a cornerstone on which collaborative solutions are commonplace, with primary interest of building a system of care in our communities that matches the needs of the individuals we serve.

SVMHI will provide current information to the *Virginia DBHDS Bed Registry* whenever there is an admission, a bed placed on hold for a pending admission, a discharge from the facility or at the end of each shift (of three shifts) when there are no changes in bed status to report.

Forty-eight beds are certified for:

- Individuals experiencing acute psychiatric crises, including those exacerbated by use of alcohol, drugs or other chemical substances, who are substantially at-risk of harm to self or to others and/or they cannot provide basic self-care or self-protection due to their psychiatric conditions;
- Individuals whose acute psychiatric crises have been treated in a private inpatient psychiatric setting but substantial risk of harm persists, requiring transfer for intermediate to long-term care;
- Individuals with forensic status who are court-ordered to SVMHI for restoration to competency and those individuals who are incarcerated in local and regional jails and are in need of acute psychiatric treatment in an inpatient setting, pending trial or after sentencing, and
- Individuals, who have been adjudicated Not-Guilty-by Reason of Insanity (NGRI), who are on conditional release in the community and are in need of acute psychiatric treatment in an inpatient setting.

Twenty-four noncertified beds are designated for individuals who have the legal status of Not Guilty By Reason of Insanity (NGRI).

Admissions Criteria

1. **Sources of Referral**

   CSB Emergency Services: A CSB Certified Emergency Services Pre-admission Screener must evaluate whether a presenting individual's mental status and accompanying behaviors pose a substantial threat of harm to self or to others or that a substantial risk of harm is evident due to the individual's inability to care for his/her basic needs or protect himself/herself due

to a mental illness or co-occurring disorder. If that level of risk is determined, the CSB Pre-admissions Screener may refer the individual for admission to SVMHI if lesser restrictive community-based alternatives for intervention are not appropriate to the level of safety and care required and a reasonable number of private inpatient facilities are not willing or do not have capacity to admit the individual. The *Regional Utilization Management Plan* includes the list of private inpatient providers used by Region VI CSBs.

CSB Representative: A qualified CSB clinician, who assesses and determines that an individual receiving treatment in a private inpatient psychiatric facility requires a longer length of stay in an inpatient environment, may refer the individual for transfer to SVMHI. The clinician will make the determination based on criteria for continuing length of stay.

Special Court Order (SCO): Judges of criminal courts within the region issue special court orders to admit individual for restoration of competency, for emergency treatment pending trial or after sentencing or individuals who have been adjudicated Not Guilty by Reason of insanity (NGRI) when Conditional Release has been revoked. Individuals with NGRI pleas in Temporary Custody may be admitted directly to SVMHI when serious safety and security risks are not evident.

Another State Inpatient Psychiatric Facility:

The Central State Hospital Forensic Unit refers individuals with NGRI legal status for transfer to SVMHI when the individuals demonstrate sufficient psychiatric stability and pose no serious safety and security risks. The individuals referred to SVMHI were adjudicated NGRI by a court within a regional jurisdiction. The purpose of the transfer is to prepare the individuals for a graduated transition to an appropriate community setting and Conditional or Unconditional Release.

Another state psychiatric facility may refer an individual for transfer to SVMHI due to humanitarian reasons or when the individual resides in the SVMHI service area.

State Correctional Facility: A State Correctional Facility may transfer individuals, referred to as Mandatory Parolees, who are released from their sentences but ordered for Involuntary Civil Commitment to a state psychiatric facility for continuing psychiatric treatment. Normally, the individuals transferred to SVMHI are those who resided in the SVMHI service area prior to their offenses.

2. **Age**

   Individuals admitted to the facility must be at least 18 years of age and not older than 64 years of age.

3. **Residency**

   - The individual resides within the catchment areas served by Danville-Pittsylvania Community Services, Piedmont Community Services, Southside Community Services or Charlotte Count, VA (Crossroads Community Services).
   - The individual is a resident outside of the catchment areas of the named CSBs but a pre-admission screening was required and it was determined by the CSB conducting the evaluation that the individual needs inpatient psychiatric treatment.
   - The individual is a resident outside of the catchment areas of the named CSBs but a Special Court Order is issued for admission by the court of the jurisdiction in which the individual's offenses occurred.
   - The individual resides outside of the catchment areas of the named CSBs but prefers to relocate to a community setting within one of the named CSBs' catchment areas.

4. **Medical Status and Other Conditions**

Medical Status: SVMHI is a state psychiatric inpatient facility, treating primary mental disorders and co-occurring disorders. Although an individual may be referred for treatment intervention due to substantial risk of harm to self and others or inability to care or protect oneself, he/she requires medical screening to ensure that he/she receives care and treatment for any medical condition in the appropriate health care environment. SVMHI has limitations in capacity to treat and care for many medical conditions. Therefore, prior to an individual's physical admission into the facility, the SVMHI physician will request a medical screening with specified tests conducted by hospital emergency department. In some cases, medical screenings are performed by medical staff of regional correctional facilities, if the individual is incarcerated.

After reviewing the screening results, the SVMHI may require further testing, a period of observation and/or treatment if:

- The individual's lab work indicates a medical condition that is significantly unstable;
- The individual requires detoxification and/or medical observation for alcohol or drug withdrawal or overdose;
- The individual requires IV fluids or medications, inpatient telemetric monitoring or surgical procedures due to a medical condition.

Limits of Capacity of SVMHI to Treat Medical Conditions: After the individual's medical condition is addressed by a health care provider in the appropriate treatment environment, the individual can be safely transported and admitted to SVMHI.

SVMHI does not have the capacity to treat primary medical conditions which may have symptoms and behaviors that are similar to psychiatric disorders. Those conditions include primary delirium, dementia, brain injury due to tumor, surgery or stroke, traumatic brain injury or brain disease unless there is clear evidence of a co-occurring serious psychiatric disorder. Individuals, who have a primary medical condition with accompanying physical combativeness, posing threat of serious injury to others, will be considered for an emergency admission by TDO, on a case-by-case basis when there is no other safe alternative for care and treatment available to prevent imminent harm and if SVMHI has adequate capacity to safely address their medical needs during the emergency admission.

Language Barriers: SVMHI provides equal opportunity for all individuals who have language barriers to have equal access to treatment and service and to make informed decisions about their care when inpatient psychiatric treatment is necessary. SVMHI will assess the individual's language limitations and his/her preference of language and communication. SVMHI will arrange for qualified interpreter services for those whose primary language is other than English and the individual has limited understanding of English. For individuals who are deaf or hearing impaired, TTY access is available and qualified interpreters proficient in American Sign Language will be available through contact with Virginia Department for the Deaf and Hard of Hearing. SVMHI complies with Department Instruction 209 (RTS) 95, on which the facility's policies and procedures are based for the provision of language access services.

Intellectual or Developmental Disability: SVMHI does not provide services to individuals who primarily have intellectual or developmental disabilities unless the individuals have evidence of co-occurring serious mental disorders. Community- based resources, through CSB programs, regional programs, such as REACH, or private services providers offer crisis stabilization services to individuals who have intellectual or developmental disabilities and are experiencing crises and will be contacted first. However, if individuals' behaviors pose serious threat of harm to self or others, emergency admission will be considered on a case-by-case basis, when there is no safe alternative available to prevent imminent harm.

REACH is a trauma-informed development disabilities response system providing mobile crisis services, such as intensive community crisis supports, crisis therapeutic homes, intensive transition supports and crisis prevention planning. Services are available through the CSBs and within the Health Planning Region in which the CSB is located (See *DBHDS Developmental Disabilities Crisis Response System, January 6, 2014*). The CSB Emergency Services clinician will conduct a pre-screening assessment of the individual in crisis and refer for REACH services. Referral for inpatient treatment and care will be only as a last resort to ensure safety and security.

5. **Legal Status**

An individual may be admitted to SVMHI's certified beds with one of the following legal statuses:

- Voluntary
- Temporary Detention Order
- Criminal Temporary Detention Order
- Involuntary Commitment
- Court Voluntary
- Emergency revocation of conditional release of an individual with NGRI status
- Special Court Order for restoration of competency to stand trial or emergency treatment pending trial or after sentencing

Admission Procedures

1. **Referral Contacts**

- Admission Social Worker
  Monday - Friday 8:00 AM – 4:30 PM
  Phone #: (434) 773-4266 Fax #: (434) 791-5405

  The admissions social worker responds to all types of admission referrals, including referrals for transfer to SVMHI. The admissions social worker consults with the SVMHI Forensic Coordinator regarding referrals to admit and individuals by Special Court Order and forensic-related referrals for transfer from other state psychiatric facilities.

- Shift Administrator
  Monday-Friday 4:30 PM until 8:00 AM next morning
  24-hours Saturday, Sunday, Holidays
  Shift administrator office: Phone # (434) 773-4250 Fax #: (434) 791-5410
  SVMHI Main Phone # (434) 799-6220

  The shift administrator responds to referrals from CSB emergency services to admit individuals needing immediate inpatient care, whether as a voluntary admission or by Temporary Detention Order.

2. **Prior Referrals to Private Psychiatric Units**

The admissions social worker or the shift administrator will ask the CSB emergency services clinician (Pre-screener) whether attempts were made to admit the individual to private psychiatric units. A reasonable number of attempts are expected to be made, at least three, unless the individual's behaviors are violent to the extent that there is high probability that a private provider would not accept the individual for admission.

If the emergency services clinician is in a situation when the four-hour Emergency Custody Order (ECO) will soon expire, the clinician will contact the magistrate to request a two-hour extension of the ECO, if additional time is needed to locate an inpatient bed. If the extended ECO is about to expire, within 30 – 45 minutes, the CSB emergency services clinician will inform the admissions social worker or shift administrator and state that there is no sufficient time left to seek a private inpatient provider for admission. The admissions social worker or shift administrator will proceed to execute the next steps in the admissions process.

The emergency services clinician will document the name of each private hospital contacted to refer the individual, the time of contact and provide a brief statement of the reason for which the admission was denied on the Pre-screening Supplement form.

3. Data and Documents Required Prior to SVMHI Accepting an Individual for Admission

The following information is to be sent to the admissions social worker or shift administrator by FAX, using the designated FAX numbers

- Completed Uniform Pre-admission Screening Form (except for Special Court Order referrals) or the Special Court Order directing the admission
- Standard set of lab test results for medical clearance
  Standard lab tests include:
    a. Vital signs
    b. History & Physical
    c. CBC
    d. CMP
    e. U/A
    f. Drug screen/BAL<0.08
    g. EKG if positive for stimulant drugs or history of cardiac disease
    h. Cardiac enzymes (CPK, CPKMB, Troponin-I) if positive for cocaine, amphetamine, PCP, methamphetamine, overdose of tricyclic antidepressant
    i. Anticonvulsive/ Mood Stabilizer levels, if prescribed
    j. Pregnancy test for females of child-bearing age
- Complete list of current medications
- Current History and Physical
- Progress notes (physician and nursing) for the last five days, if the individual is being referred for transfer
- Warrant, indictment, criminal complaint to indicate current charges/convictions, if the individual is incarcerated
- Third party reimbursement information, if available
- For acute admission referrals, the name of the ED Attending Physician conducting the medical evaluation and the phone number

4. Documents Required Prior to Admission

- Petition for Involuntary Commitment
- Temporary Detention Order
- ED summary/transfer documents
- Commitment documents (if individual is being transferred)
- MARS (if individual is being transferred)

5. Acceptance for Admission

a. Acute Admissions

1. The CSB emergency services clinician makes the determination that the individual meets the criteria for inpatient evaluation and treatment prior to the referral. The admissions social worker or shift administrator determines whether the individual meets the criteria for admission to SVMHI, based on the criteria stated in this document. The SVMHI physician will determine whether the facility has the capacity to treat any medical need the referred individual might have or whether further testing, observation or treatment is necessary prior to the individual's being transported to SVMHI.

2. If the individual meets the criteria for admission to SVMHI, the admissions social worker or shift administrator will state to the CSB emergency services clinician, *"The individual is accepted, pending the SVMHI physician's determination of when the individual is medically appropriate for admission."*

3. Although the SVMHI physician may determine that further testing, observation or treatment is indicated before the individual can be transported for admission, the CSB emergency services clinician will be enabled to obtain a Temporary Detention Order (TDO), when the individual is not willing or capable of being admitted on a voluntary basis. It is crucial that the CSB emergency services clinician communicate to the hospital Emergency Department attending physician that the individual cannot be admitted to SVMHI until the SVMHI physician is satisfied that the individual is medically stable to be admitted.

   When the magistrate is contacted to obtain the TDO, the CSB emergency services clinician will communicate the need for the individual to be transported, prior to transport to the TDO facility, for medical evaluation and medical treatment as may be required by a physician at the temporary detention facility.

4. When the lab results and medical evaluation reports are received, the admissions social worker or shift administrator will organize the reports that have been faxed and relay the information to the SVMHI physician on-call, along with the name and phone number of the ED attending physician.

5. After review of the medical reports, the SVMHI on-call physician will communicate to the admissions social worker or shift administrator that the individual has no apparent medical barriers to admission. If the SVMHI physician has questions or concerns about the individual's medical stability, the SVMHI physician will directly contact the ED attending physician toward resolving the questions or concerns. The SVMHI physician may request further testing, retesting or a period of observation. Inpatient medical treatment may be indicated. The SVMHI physician will communicate the outcome to the admissions social worker or shift administrator, who will relay the information to the CSB emergency services clinician. The individual will continue to be on a TDO until medically stable to be admitted to SVMHI.

6. When the individual is determined to be medically appropriate for admission, the CSB emergency services clinician will be notified. The CSB emergency services clinician will notify the ED attending physician and law enforcement officers that the individual is ready for transport to the facility for admission.

7. The CSB emergency services clinician, with cooperation of ED staff, will ensure that law enforcement officers who will transport the individual to SVMHI are provided with the necessary documents to relay to the SVMHI shift administrator at the time of arrival.

Those documents include the signed Petition for Involuntary Commitment, (issued by the magistrate at the time of the ECO) a signed Temporary Detention Order (issued by the magistrate at the time of the ECO) and ED summary /transfer documents

b. Transfers from Private Inpatient or Other State Facilities

1. Referrals for transfer from private inpatient providers will be received Monday – Friday, from 8:00 AM – 4:30 PM by the admissions social worker. The referral will be made by a CSB clinician who has assessed the clinical necessity of an individual to be transferred for longer term treatment. The CSB clinician will request that the private provider send by FAX the required data and documentation (see Admissions procedures #3) to the admissions social worker. The admissions social worker will coordinate the transfer arrangements with the private inpatient provider.

   If SVMHI is at maximum capacity, the individual will be placed on a waiting list for transfer. Those individuals on the waiting list whose inpatient stay and treatment are covered by CSB Local Inpatient Purchase of Service (LIPOS) funds will be priority for transfer.

   In the instance when an individual's symptoms and behaviors cannot be safely managed by a private provider, due to current serious dangerousness, CSB Emergency Services will be notified. The CSB Emergency Services Clinician will refer the individual for an immediate transfer.
2. Referrals for a transfer of an individual from another state psychiatric facility are received Monday-Friday, from 8:00 AM - 4:30 PM, normally by the admissions social worker, if the individual is not one with NGRI status subject to civil transfer from Central State Hospital (CSH). Such requests may be for humanitarian reasons or due to the individual's preference to be treated at SVMHI. The admissions social worker will relay the request to the SVMHI facility director, who will consult with the referring facility director prior to a decision to accept the transfer. If accepted, the admissions social worker will coordinate the transfer arrangements with the admissions staff of the referring facility.

   Civil transfers of individuals with NGRI status from CSH are normally received by the SVMHI Forensic Coordinator, who facilitates the arrangements with the CSH Forensic Coordinator.

c. Special Court Orders

Regardless of the means of initial contact, Special Court Orders for admission to SVMHI are forwarded to the SVMHI admissions social worker, who facilitates arrangements for the admission of the individual.

Acute Admissions when SVMHI is at Full Census/Delay in Process

SVMHI maintains 48 beds on civil units for acute admissions and there are instances when the census is at full capacity. However, SVMHI, as a state facility, continues its commitment to act as a "safety net" for individuals in its region who are experiencing psychiatric emergencies when timely appropriate alternatives are not available. Therefore, the following procedures are established for referrals for acute admissions when SVMHI is at full capacity or when there is excessive delay in obtaining acceptance for a referral.

1. The CSB emergency services clinician will contact the emergency services supervisor on-call to provide specific information about the situation.
2. CSB emergency services coordinators and supervisors are provided monthly SVMHI administrator on-call schedules and any subsequent updates. During the hours of 8:00 AM and 5:00 PM, Monday – Friday, the emergency services supervisor may contact the SVMHI clinical director at (434) 773 4229 or (434) 799-6220 (SVMHI main number). All other times, the CSB emergency services supervisor may contact the administrator on-call listed on the schedule.

3. The specific difficulties concerning the admission referral will be relayed and the two parties will collaborate on a problem resolution. If the situation involves bed reassignments on the care units to accommodate the new admission, the clinical director or administrator on-call will consult with the unit nurse managers to communicate the need and to be informed of the arrangement to be made.
4. The CSB emergency services supervisor will be informed of the arrangement and will relay the information to the CSB emergency services clinician. The clinical director or administrator on-call will confirm acceptance with the admissions social worker or shift administrator. Communications between the CSB emergency services clinician and the admissions social worker or shift administrator will resume for completing the procedures for the individual's admission.
5. The SVMHI facility director will collaborate with regional CSBs, regional private inpatient providers and/or other state psychiatric facilities to develop contingency plans in the event that there are multiple referrals for admission when the facility is at full capacity. After exhausting all other options, the SVMHI facility director is ultimately responsible to locate a safe and secure bed for an individual who requires a psychiatric inpatient care.

6. When SVMHI has exceeded bed capacity, the SVMHI clinical director will notify the members of the Regional Utilization Management Committee and the individuals' respective SVMHI treatment teams to initiate urgent review of individuals receiving services from SVMHI who are clinically ready for discharge. The purpose of the urgent review will be to determine if there are individuals whose discharge plans can be accelerated. If so, the behavioral health directors of the CSBs will dispatch the Discharge Liaisons to complete the discharge planning for the individuals who can be expeditiously discharged, in collaboration with the treatment teams' social workers.

Southside Behavioral Health Consortium Utilization Management Plan

The Southside Behavioral Health Consortium (SBHC) maintains a regional plan for effectively managing the utilization of inpatient psychiatric beds for adult individuals receiving services (See *Southside Behavioral Health Consortium Utilization Management Plan 2014*). The plan will be coupled with the Regional Admissions Protocols in order to emphasize the necessity of planned management throughout the regional system of behavioral health care. The plan will be reviewed annually by the Regional Utilization Management Committee and submitted to the SBHC with revisions as indicated. The plan includes the following:

- Objectives to be met in order to fulfill effective utilization management
- Management of admissions to private behavioral health providers and utilization of LIPOS funds to purchase bed days
- Management of admissions to the regional residential crisis stabilization services (Foundation House) and utilization of LIPOS to purchase bed days

- Management of Admissions and Discharges from SVMHI
- SVMHI internal utilization management relating to the individual's clinical course of treatment.

Annual Review of Protocols

The SBHC will review the Protocols for Admissions to SVMHI annually, from the date adopted and approved. The SBHC will also review periodic evaluation reports submitted by the RUM Committee and direct the execution of strategies developed to address and remedy challenges and difficulties encountered in fulfilling the protocols' essential purpose.

The SBHC approved the Protocols for Admissions to SVMHI on this day, March 10, 2014.

_____	_____
Jim Bebeau, Executive Director Danville-Pittsylvania Community Services SBHC Chairperson	Jim Tobin, Executive Director, Piedmont Community Services
_____	_____
Don Burge, Executive Director Southside Community Services	Daniel L. Herr, Facility Director Southern Virginia mental Health Institute

REGION V

PARTNERSHIP PLANNING REGION VII ADMISSION PROTOCOL

The following processes are followed during assessment, referral, and inpatient admission of individuals experiencing a psychiatric crisis and in need of a TDO, with the underlying principle that the individual is the most important part of the process and deserves the right treatment, in the right setting, at the right time, improving his/her chances for recovery, as well as the individual's safety and that of the public. Individual client circumstances and clinician judgment of appropriate placements make each emergency assessment unique.

Accessing a psychiatric bed for a TDO:

- Once the CSB Emergency Services (ES) clinician has completed the assessment and determined that a TDO is needed, the Psychiatric Bed Registry is reviewed for information to assist in determining bed availability. If the individual is currently at a hospital, medical screening is requested at the time of assessment.

- CSB Emergency Services clinicians consider the possible appropriateness of CSU before calling local hospitals. Exclusion criteria for CSU would be acute suicidal ideation with clear intent, aggressive acting out behaviors, being acutely psychotic, posing a significant flight risk, and refusing treatment. Following review of all of the information received from the prescreener, CSU calls the doctor on call for medical clearance for admission. CSU can be optimally utilized for stepdowns from both state and acute care facilities.

- If CSU is not appropriate, Connect or RESPOND® are contacted; the first call is usually dependent on which hospital is currently serving the client. For both CSBs, a local bed is always preferable.

    - Connect and RESPOND® will review all information on the patient if there are available beds, before discussing the admission with the physician. They emphasize the safety of the individual with regard to all medical issues. If a bed is available, the attending physician makes the decision regarding admission.
    - If the individual is accepted for hospital admission, Connect or RESPOND® calls the unit for a bed assignment and contacts the CSB with bed information.
    - If there are no beds available or admission denied, the ES clinician is notified by Connect or RESPOND®.
    - Except in extenuating circumstances, hospitals will respond with acceptance or denial of the admission within 20-30 minutes from call by the ES clinician.

- If there are no beds at LewisGale Behavioral Health or Carilion Psychiatry, the ES clinician begins making calls for an available bed outside the region, with no more than 5-10 minutes between calls. Multiple bed placements can be pursued simultaneously. The list of primary and secondary hospitals which can be called are attached as Addendum A of this protocol.

- Admission to the Salem VA Medical Center can be considered for qualifying veterans. The VA will review ECO/TDOs during work hours (M-F 8-4:30). If the individual is already in a bed, they will accept after the hearing if it is an appropriate admission.

- Deaf or hearing impaired individuals will be treated as any other individual without discrimination and Western State Hospital may be considered if the individual knows ASL.

- For individuals with confirmed or suspected intellectual disability, the ES clinician will contact REACH (formerly START) for crisis response, consultation, and resources at 1-855-887-8278.

- No later than hour 3 of an ECO, or at hour 3 of the prescreening process when a TDO is being pursued without an ECO, the emergency services clinician will give a "heads up" call to the Catawba Director of Social Work during regular business hours or to the Nursing Supervisor after hours/weekends. This process applies to both adult and geriatric admissions.

    - Information relayed will include the fact that a TDO bed is being pursued but has not yet been obtained and there is a possibility that a safety net bed at a State Hospital might be needed. At that time, relevant client information/prescreening form will be also faxed to Catawba. This call should be made even earlier if the clinician has the needed information and perceives that there might be a bed issue.
    - At that time, Catawba will begin immediate review of the information faxed for any additional medical considerations/testing which may be needed. The Catawba physician reviews for medical clearance. The Nursing Supervisor also looks at the information for any potential nursing issues. If there are medical clearance issues, the Catawba physician contacts the ER physician to discuss. If there are any problems, the Catawba Chief of Staff is notified. After hours, the Nursing Supervisor calls the social worker on call to review the information.
    - Following this heads up call to Catawba, the ES clinician will continue to pursue alternative bed placement at other facilities. If other facility placements appear more likely, the approval process is not completed beyond the initial call and review of faxed prescreening until the follow-up call from the CSB at 4.5 hours.

- An ECO extension is obtained prior to the expiration of the 4 hour ECO and the ES clinician continues to make additional calls to facilities for possible admission. If, at hour 4.5, another placement has not been found and a safety net bed is needed for either an adult or geriatric individual, the ES clinician will contact his/her supervisor, who will contact the CSB Mental Health Director or designee, who will then contact the Catawba Director, or designee, to secure a safety net bed.
    - Once the Catawba Director/designee is notified, the approval process for a bed at Catawba continues, with review by the physician and nursing supervisor.
    - The Social Work Director during the day or the Nursing Supervisor afterhours notifies the CSB of acceptance.
- If no safety net bed is available at Catawba, the Hospital Director contacts other State facilities for possible placement.

Medical Screening:

- The region appreciates the clinical, legal and ethical importance of medical screening to eliminate possible medical causes for a person's presenting psychiatric symptoms and signs. As there are a number of rapidly lethal medical conditions that may manifest common psychiatric symptoms, the ability to identify these conditions and make appropriate early interventions is vital. A wide range of medical conditions and treatments may result in abnormal behavior, and many medical disorders may produce or exacerbate psychiatric symptoms in patients with pre-existing mental illness. Failure to detect and diagnose underlying medical disorders may result in significant and unnecessary morbidity and mortality, invasion of an individual's life and constitutionally guaranteed liberties, and liability to community systems and transferring physicians. Transfer of patients with acute or unstable medical conditions from a local hospital to a state facility may constitute a violation of the *Comprehensive Omnibus Budget*

Reconciliation Act (COBRA) of 1996 (as revised) and the *Emergency Medical Treatment and Active Labor Act (EMTALA)*. CSB's should have the capability to divert individuals with acute medical conditions who do not meet facility admission criteria to appropriate medical facilities. Individuals whose medical assessments indicate the presence of an acute or unstable medical condition must be referred by the CSB for immediate treatment in an appropriate medical facility.

- The reason that the patient presents in the ED guides the scope of the medical screening. Additional medical screening tests requested by a potential admitting facility may impact the timeline of the process. Communication with physicians is key for making the right decisions with all available medical information.

Transfers and Discharge Planning:

- If an individual is placed in a State facility outside of the region, the CSB of origin will work to get the patient back to this area as soon as possible. The CSB communicates with the out of region State facility, obtains patient information, and works with Catawba or CSU to set up the transfer. The patient would likely not be transferred if he/she were going to be released at the hearing or shortly thereafter.
- Transfers from a private hospital to Catawba are coordinated through the regional Census Management Team (CMT). Individuals are considered for CMT discussion if they need a more intensive level of in-patient care.
- CMT does <u>not</u> discuss the following:
    - Voluntary admissions
    - Geriatric admissions.
    - Individuals on medical units who have not been TDO'd.
    - Admitted patients prior to the TDO hearing will not be discussed, ***<u>except</u>*** in the following situation:
        i. Person is a known consumer of services
        ii. The hearing is being held that day and staff is certain the patient will be committed.
        iii. Based on knowledge of person and acuity of current symptoms, the patient requires a different level of care than is currently being provided.
- Based on presentation of patients, the CMT members then discuss the appropriate level of care needed for the individual. They will prioritize based on acuity of patient symptoms for level of care needed and available beds.
- Documentation typically required for transfer from private facility to Catawba includes:
    - The most recent CSB prescreening
    - Current commitment papers
    - History and Physical
    - Medication list
    - Labs (whatever has been done – usually CBC, CMP, UDS)
    - Vitals
    - EKG and chest X-Ray, if they have been done
    - Notes (physician, nursing, social work)

Utilization Management:

- The region will develop a coordinated process for regional utilization management that will focus on patient flow metrics, i.e., admissions, discharges, number of TDOs, insured/uninsured issues, extraordinary barriers list, and overall bed utilization. This group will consist of current

members of CMT, as well as State Hospital discharge planners, CSB emergency service representatives, Connect and Respond representatives, CSB Mental Health Directors, and Catawba Chief of Staff. It is important that both the admission and discharge clinicians work together with the ability to expand patient diversions.

- Information on expired TDOs is to be sent to the Regional Manager by the next business day. The Regional Manager will report this information to DBHDS as directed.

ADDENDUM A-PPR 7 Primary and Secondary Hospital List (attached)

REGION VII

Southside Behavioral Health Consortium - Region VI

Protocols for Admissions to Southern Virginia Mental Health Institute
And
Regional Utilization Plan
DRAFT #7 (2/24/14)

Purpose

Southern Virginia Mental Health Institute (SVMHI) is a seventy-two-bed psychiatric inpatient treatment facility of the Commonwealth of Virginia. SVMHI admits individuals served by Piedmont Community Services (PCS), Danville-Pittsylvania Community Services (DPCS), Southside Community Services and Charlotte County (Crossroads Community Services).

Being a public facility of the Commonwealth of Virginia, it is an explicit role for SVMHI to serve as a "safety net" for those in need of inpatient care to ensure a safe, secure and caring environment by which individuals might receive swift and clinically appropriate interventions when no lesser level of care sufficient to the degree of need or when no private care resources are available. This document will disclose specific criteria for admissions, specific procedures and roles for the varying types of admissions and will also provide procedures to follow when the SVMHI's certified bed census is at 48 or above and an individual is in need of state inpatient psychiatric care.

The partnership between Community Services Boards, private providers of care and services, advocacy groups and SVMHI has provided a cornerstone on which collaborative solutions are commonplace, with primary interest of building a system of care in our communities that matches the needs of the individuals we serve.

SVMHI will provide current information to the *Virginia DBHDS Bed Registry* whenever there is an admission, a bed placed on hold for a pending admission, a discharge from the facility or at the end of each shift (of three shifts) when there are no changes in bed status to report.

Forty-eight beds are certified for:

- Individuals experiencing acute psychiatric crises, including those exacerbated by use of alcohol, drugs or other chemical substances, who are substantially at-risk of harm to self or to others and/or they cannot provide basic self-care or self-protection due to their psychiatric conditions;
- Individuals whose acute psychiatric crises have been treated in a private inpatient psychiatric setting but substantial risk of harm persists, requiring transfer for intermediate to long-term care;
- Individuals with forensic status who are court-ordered to SVMHI for restoration to competency and those individuals who are incarcerated in local and regional jails and are in need of acute psychiatric treatment in an inpatient setting, pending trial or after sentencing;
- Individuals, who have been adjudicated Not-Guilty-by Reason of Insanity (NGRI), who are on conditional release in the community and are in need of acute psychiatric treatment in an inpatient setting.

Twenty-four noncertified beds are designated for individuals who have the legal status of Not Guilty By Reason of Insanity (NGRI).

Admissions Criteria

6. **Sources of Referral**

CSB Emergency Services: A CSB Certified Emergency Services Pre-admission Screener must evaluate whether a presenting individual's mental status and accompanying behaviors pose a substantial threat of harm to self or to others or that a substantial risk of harm is evident due to the individual's inability to care for his/her basic needs or protect himself/herself due to a mental illness or co-occurring disorder. If that level of risk is determined, the CSB Pre-admissions Screener may refer the individual for admission to SVMHI if lesser restrictive community-based alternatives for intervention are not appropriate to the level of safety and care required and a reasonable number of private inpatient facilities are not willing or do not have capacity to admit the individual. The *Regional Utilization Management Plan* includes the list of private inpatient providers used by Region VI CSBs.

CSB Representative: A qualified CSB clinician, who assesses and determines that an individual receiving treatment in a private inpatient psychiatric facility requires a longer length of stay in an inpatient environment, may refer the individual for transfer to SVMHI. The clinician will make the determination based on criteria for continuing length of stay.

Special Court Order (SCO): Judges of criminal courts within the region issue special court orders to admit individual for restoration of competency, for emergency treatment pending trial or after sentencing or individuals who have been adjudicated Not Guilty by Reason of insanity (NGRI) when Conditional Release has been revoked. Individuals with NGRI pleas in Temporary Custody may be admitted directly to SVMHI when serious safety and security risks are not evident.

Another State Inpatient Psychiatric Facility:

The Central State Hospital Forensic Unit refers individuals with NGRI legal status for transfer to SVMHI when the individuals demonstrate sufficient psychiatric stability and pose no serious safety and security risks. The individuals referred to SVMHI were adjudicated NGRI by a court within a regional jurisdiction. The purpose of the transfer is to prepare the individuals for a graduated transition to an appropriate community setting and Conditional or Unconditional Release.

Another state psychiatric facility may refer an individual for transfer to SVMHI due to humanitarian reasons or when the individual resides in the SVMHI service area.

State Correctional Facility: A State Correctional Facility may transfer individuals, referred to as Mandatory Parolees, who are released from their sentences but ordered for Involuntary Civil Commitment to a state psychiatric facility for continuing psychiatric treatment. Normally, the individuals transferred to SVMHI are those who resided in the SVMHI service area prior to their offenses.

7. **Age**

   Individuals admitted to the facility must be at least 18 years of age and not older than 64 years of age.

8. **Residency**

   - The individual resides within the catchment areas served by Danville-Pittsylvania Community Services, Piedmont Community Services, Southside Community Services or Charlotte Count, VA (Crossroads Community Services).
   - The individual is a resident outside of the catchment areas of the named CSBs but a pre-admission screening was required and it was determined by the CSB conducting the evaluation that the individual needs inpatient psychiatric treatment.
   - The individual is a resident outside of the catchment areas of the named CSBs but a Special Court Order is issued for admission by the court of the jurisdiction in which the individual's offenses occurred.

- The individual resides outside of the catchment areas of the named CSBs but prefers to relocate to a community setting within one of the named CSBs' catchment areas.

9. **Medical Status and Other Conditions**

Medical Status: SVMHI is a state psychiatric inpatient facility, treating primary mental disorders and co-occurring disorders. Although an individual may be referred for treatment intervention due to substantial risk of harm to self and others or inability to care or protect oneself, he/she requires medical screening to ensure that he/she receives care and treatment for any medical condition in the appropriate health care environment. SVMHI has limitations in capacity to treat and care for many medical conditions. Therefore, prior to an individual's physical admission into the facility, the SVMHI physician will request a medical screening with specified tests conducted by hospital emergency department. In some cases, medical screenings are performed by medical staff of regional correctional facilities, if the individual is incarcerated.

After reviewing the screening results, the SVMHI may require further testing, a period of observation and/or treatment if:

- The individual's lab work indicates a medical condition that is significantly unstable;
- The individual requires detoxification and/or medical observation for alcohol or drug withdrawal or overdose;
- The individual requires IV fluids or medications, inpatient telemetric monitoring or surgical procedures due to a medical condition.

Limits of Capacity of SVMHI to Treat Medical Conditions: After the individual's medical condition is addressed by a health care provider in the appropriate treatment environment, the individual can be safely transported and admitted to SVMHI.

SVMHI does not have the capacity to treat primary medical conditions which may have symptoms and behaviors that are similar to psychiatric disorders. Those conditions include primary delirium, dementia, brain injury due to tumor, surgery or stroke, traumatic brain injury or brain disease unless there is clear evidence of a co-occurring serious psychiatric disorder. Individuals, who have a primary medical condition with accompanying physical combativeness, posing threat of serious injury to others, will be considered for an emergency admission by TDO, on a case-by-case basis when there is no other safe alternative for care and treatment available to prevent imminent harm and if SVMHI has adequate capacity to safely address their medical needs during the emergency admission.

Intellectual or Developmental Disability: SVMHI does not serve individuals who primarily have intellectual or developmental disabilities unless the individuals have evidence of co-occurring serious mental disorders. Community- based resources, through CSB programs, regional programs, such as REACH or START, or private services providers offer crisis stabilization services to individuals who have intellectual or developmental disabilities are experiencing crises and will be contacted first. However, if individuals' behaviors pose serious threat of harm to self or others, emergency admission will be considered on a case-by-case basis, when there is no safe alternative available to prevent imminent harm.

10. **Legal Status**

An individual may be admitted to SVMHI's certified beds with one of the following legal statuses:

- Voluntary
- Temporary Detention Order
- Criminal Temporary Detention Order

- Involuntary Commitment
- Court Voluntary
- Emergency revocation of conditional release of an individual with NGRI status
- Special Court Order for restoration of competency to stand trial or emergency treatment pending trial or after sentencing

Admission Procedures

6. **Referral Contacts**

   - Admission Social Worker
     Monday - Friday 8:00 AM – 4:30 PM
     Phone #: (434) 773-4266 Fax #: (434) 791-5405

     The admissions social worker responds to all types of admission referrals, including referrals for transfer to SVMHI. The admissions social worker consults with the SVMHI Forensic Coordinator regarding referrals to admit and individuals by Special Court Order and forensic-related referrals for transfer from other state psychiatric facilities.

   - Shift Administrator
     Monday-Friday 4:30 PM until 8:00 AM next morning
     24-hours Saturday, Sunday, Holidays
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     SVMHI Main Phone # (434) 799-6220

     The shift administrator responds to referrals from CSB emergency services to admit individuals needing immediate inpatient care, whether as a voluntary admission or by Temporary Detention Order.

7. **Prior Referrals to Private Psychiatric Units**

   The admissions social worker or the shift administrator will ask the CSB emergency services clinician (Pre-screener) whether attempts were made to admit the individual to private psychiatric units. A reasonable number of attempts are expected to be made, at least three, unless the individual's behaviors are violent to the extent that there is high probability that a private provider would not accept the individual for admission.

   If the emergency services clinician is in a situation when the four-hour Emergency Custody Order (ECO) will soon expire, the clinician will contact the magistrate to request a two-hour extension of the ECO, if additional time is needed to locate an inpatient bed. If the extended ECO is about to expire, within 30 – 45 minutes, the CSB emergency services clinician will inform the admissions social worker or shift administrator and state that there is no sufficient time left to seek a private inpatient provider for admission. The admissions social worker or shift administrator will proceed to execute the next steps in the admissions process.

   The emergency services clinician will document the name of each private hospital contacted to refer the individual, the time of contact and provide a brief statement of the reason for which the admission was denied on the Pre-screening Supplement form.

8. **Data and Documents Required Prior to SVMHI Accepting an Individual for Admission**

   The following information is to be sent to the admissions social worker or shift administrator by FAX, using the designated FAX numbers

- Completed Uniform Pre-admission Screening Form (except for Special Court Order referrals) or the Special Court Order directing the admission
- Standard set of lab test results for medical clearance
  Standard lab tests include:
    k. Vital signs
    l. History & Physical
    m. CBC
    n. CMP
    o. U/A
    p. Drug screen/BAL<0.08
    q. EKG if positive for stimulant drugs or history of cardiac disease
    r. Cardiac enzymes (CPK, CPKMB, Troponin-I) if positive for cocaine, amphetamine, PCP, methamphetamine, overdose of tricyclic antidepressant
    s. Anticonvulsive/ Mood Stabilizer levels, if prescribed
    t. Pregnancy test for females of child-bearing age
- Complete list of current medications
- Current History and Physical
- Progress notes (physician and nursing) for the last five days, if the individual is being referred for transfer
- Warrant, indictment, criminal complaint to indicate current charges/convictions, if the individual is incarcerated
- Third party reimbursement information, if available
- For acute admission referrals, the name of the ED Attending Physician conducting the medical evaluation and the phone number

9. <u>Documents Required Prior to Admission</u>

- Petition for Involuntary Commitment
- Temporary Detention Order
- ED summary/transfer documents
- Commitment documents (if individual is being transferred)
- MARS (if individual is being transferred)

10. <u>Acceptance for Admission</u>

d. Acute Admissions

8. The CSB emergency services clinician makes the determination that the individual meets the criteria for inpatient evaluation and treatment prior to the referral. The admissions social worker or shift administrator determines whether the individual meets the criteria for admission to SVMHI, based on the criteria stated in this document. The SVMHI physician will determine whether the facility has the capacity to treat any medical need the referred individual might have or whether further testing, observation or treatment is necessary prior to the individual's being transported to SVMHI.

9. If the individual meets the criteria for admission to SVMHI, the admissions social worker or shift administrator will state to the CSB emergency services clinician, *"The individual is accepted, pending the SVMHI physician's determination of when the individual is medically appropriate for admission."*

10. Although the SVMHI physician may determine that further testing, observation or treatment is indicated before the individual can be transported for admission, the CSB emergency services clinician will be enabled to obtain a Temporary Detention Order (TDO), when the individual is not willing or capable of being admitted on a voluntary

basis. It is crucial that the CSB emergency services clinician communicate to the hospital Emergency Department attending physician that the individual cannot be admitted to SVMHI until the SVMHI physician is satisfied that the individual is medically stable to be admitted.

When the magistrate is contacted to obtain the TDO, the CSB emergency services clinician will communicate the need for the individual to be transported, prior to transport to the TDO facility, for medical evaluation and medical treatment as may be required by a physician at the temporary detention facility.

11. When the lab results and medical evaluation reports are received, the admissions social worker or shift administrator will organize the reports that have been faxed and relay the information to the SVMHI physician on-call, along with the name and phone number of the ED attending physician.

12. After review of the medical reports, the SVMHI on-call physician will communicate to the admissions social worker or shift administrator that the individual has no apparent medical barriers to admission. If the SVMHI physician has questions or concerns about the individual's medical stability, the SVMHI physician will directly contact the ED attending physician toward resolving the questions or concerns. The SVMHI physician may request further testing, retesting or a period of observation. Inpatient medical treatment may be indicated. The SVMHI physician will communicate the outcome to the admissions social worker or shift administrator, who will relay the information to the CSB emergency services clinician. The individual will continue to be on a TDO until medically stable to be admitted to SVMHI.

13. When the individual is determined to be medically appropriate for admission, the CSB emergency services clinician will be notified. The CSB emergency services clinician will notify the ED attending physician and law enforcement officers that the individual is ready for transport to the facility for admission.

14. The CSB emergency services clinician, with cooperation of ED staff, will ensure that law enforcement officers who will transport the individual to SVMHI are provided with the necessary documents to relay to the SVMHI shift administrator at the time of arrival. Those documents include the signed Petition for Involuntary Commitment, (issued by the magistrate at the time of the ECO) a signed Temporary Detention Order (issued by the magistrate at the time of the ECO) and ED summary /transfer documents

e. Transfers from Private Inpatient or Other State Facilities

3. Referrals for transfer from private inpatient providers will be received Monday – Friday, from 8:00 AM – 4:30 PM by the admissions social worker. The referral will be made by a CSB clinician who has assessed the clinical necessity of an individual to be transferred for longer term treatment. The CSB clinician will request that the private provider send by FAX the required data and documentation (see Admissions procedures #3) to the admissions social worker. The admissions social worker will coordinate the transfer arrangements with the private inpatient provider.

   If SVMHI is at maximum capacity, the individual will be placed on a waiting list for transfer. Those individuals on the waiting list whose inpatient stay and treatment are covered by CSB Local Inpatient Purchase of Service (LIPOS) funds will be priority for transfer.

In the instance when an individual's symptoms and behaviors cannot be safely managed by a private provider, due to current serious dangerousness, CSB Emergency Services will be notified. The CSB Emergency Services Clinician will refer the individual for an immediate transfer.

4. Referrals for a transfer of an individual from another state psychiatric facility are received Monday-Friday, from 8:00 AM - 4:30 PM, normally by the admissions social worker, if the individual is not one with NGRI status subject to civil transfer from Central State Hospital (CSH). Such requests may be for humanitarian reasons or due to the individual's preference to be treated at SVMHI. The admissions social worker will relay the request to the SVMHI facility director, who will consult with the referring facility director prior to a decision to accept the transfer. If accepted, the admissions social worker will coordinate the transfer arrangements with the admissions staff of the referring facility.

   Civil transfers of individuals with NGRI status from CSH are normally received by the SVMHI Forensic Coordinator, who facilitates the arrangements with the CSH Forensic Coordinator.

f. Special Court Orders

Regardless of the means of initial contact, Special Court Orders for admission to SVMHI are forwarded to the SVMHI admissions social worker, who facilitates arrangements for the admission of the individual.

Utilization Management

Acute Admissions when SVMHI is at Full Census/Delay in Process

SVMHI maintains 48 beds on civil units for acute admissions and there are instances when the census is at full capacity. However, SVMHI, as a state facility, continues its commitment to act as a "safety net" for individuals in its region who are experiencing psychiatric emergencies when timely appropriate alternatives are not available. Therefore, the following procedures are established for referrals for acute admissions when SVMHI is at full capacity or when there is excessive delay in obtaining acceptance for a referral.

7. The CSB emergency services clinician will contact the emergency services supervisor on-call to provide specific information about the situation.
8. CSB emergency services coordinators and supervisors are provided monthly SVMHI administrator on-call schedules and any subsequent updates. During the hours of 8:00 AM and 5:00 PM, Monday – Friday, the emergency services supervisor may contact the SVMHI clinical director at (434) 773 4229 or (434) 799-6220 (SVMHI main number). All other times, the CSB emergency services supervisor may contact the administrator on-call listed on the schedule.
9. The specific difficulties concerning the admission referral will be relayed and the two parties will collaborate on a problem resolution. If the situation involves bed reassignments on the care units to accommodate the new admission, the clinical director or administrator on-call will consult with the unit nurse managers to communicate the need and to be informed of the arrangement to be made.
10. The CSB emergency services supervisor will be informed of the arrangement and will relay the information to the CSB emergency services clinician. The clinical director or administrator on-call will confirm acceptance with the admissions social worker or shift administrator. Communications between the CSB emergency services clinician and the admissions social

worker or shift administrator will resume for completing the procedures for the individual's admission.

11. The SVMHI facility director will collaborate with regional CSBs, regional private inpatient providers and/or other state psychiatric facilities to develop contingency plans in the event that there are multiple referrals for admission when the facility is at full capacity. The SVMHI facility director is ultimately responsible to locate a safe and secure bed for an individual who requires a psychiatric inpatient care.

12. When SVMHI has exceeded bed capacity, the SVMHI clinical director will notify the members of the Regional Utilization Management Committee and the individuals' respective SVMHI treatment teams to initiate urgent review of individuals receiving services from SVMHI who are clinically ready for discharge. The purpose of the urgent review will be to determine if there are individuals whose discharge plans can be accelerated. If so, the behavioral health directors of the CSBs will dispatch the Discharge Liaisons to complete the discharge planning for the individuals who can be expeditiously discharged, in collaboration with the treatment teams' social workers.

Annual Review of Protocols

The SBHC will review the Protocols for Admissions to SVMHI annually, from the date adopted and approved. The SBHC will also review periodic evaluation reports submitted by the RUM Committee and direct the execution of strategies developed to address and remedy challenges and difficulties encountered in fulfilling the protocols' essential purpose.

Southside Behavioral Health Consortium Utilization Management Plan

Purpose and Function

The Southside Behavioral Health Consortium (SBHC) is committed to providing recovery-oriented inpatient care and other effective community-based behavioral health interventions in the safest, least restrictive environments possible, optimally utilizing the various resources available within the Southside region. Ten objectives are established to better fulfill this goal:

- To strengthen the continuity of care for individuals receiving services through collaborative endeavors between private and public care providers, responding to individuals' levels of need with appropriate levels of care;

- To strengthen the procedural aspects of behavioral health services delivery toward creating a seamless system of care within the SBHC services areas.

- To serve individuals receiving services within their community of residence to the extent possible;

- To respect individuals' preferences to the extent possible and appropriate when psychiatric interventions are indicated;

- To maximize utilization of private, inpatient behavioral health providers for individuals requiring intensive care for acute conditions;

- To utilize the regional residential crisis stabilization services, operated by Danville-Pittsylvania Community Services, for individuals whose crises can be resolved in a lesser restrictive treatment environment than inpatient services provides;

- To maximize utilization of Southern Virginia Mental Health Institute (SVMHI) for individuals requiring intermediate care and psychosocial rehabilitation;

- To ensure timely and cost effective means of delivering inpatient psychiatric care;

- To maintain a census at SVMHI at or below funded levels (up to 48 certified beds and 24 non-certified beds);

- To manage the discharges of individuals from inpatient settings to their home environments as rapidly as possible, with necessary community supports mobilized to promote ongoing stability for them as they live in the community setting of their choice.

Utilization management is a functional process integral to fulfilling the goals and objectives set forth by the Southside Behavioral Health Consortium. Four strategic functions will be implemented to achieve objectives:

1. *Management of admissions and bed day purchases from private behavioral health providers;*
2. *Management of admissions and discharges from SVMHI;*
3. *Regional Partnerships*
4. *Management of the clinical course of treatment and length of stay at SVMHI*

Regional Utilization Management Committee: The SBHC will maintain the established Regional Utilization Management Committee (RUM). The RUM Committee will oversee the application of the four utilization management functions, establish goals and strategies to achieve them, with empirical outcome measures, identify and collect data pertinent to utilization management, prepare regular reports to the SBHC and provide recommendations to the SBHC for operational changes as needed.

The committee is comprised of the following members:

- The SVMHI Director of Clinical Services, who serves as the Consortium's designated Regional Project Manager for Region VI, which is the SBHC services area.
- Behavioral Health Directors of Danville-Pittsylvania Community Services (DPCS), Southside Community Services(SCS) and Piedmont Community Services (PCS)
- The DPCS Director of Finance (DPCS is the SBHC fiscal agent for regional funds)
- Behavioral health finance managers for DPCS, SCS and PCS

DPCS, SCS, PCS and SVMHI contribute administrative funds to support the position of Regional Data Technician, employed by SVMHI, to provide administrative assistance to the RUM Committee.

The RUM Committee meets on the fourth Monday of each month and at other times as required to conduct business. The committee welcomes the attendance and participation of DBHDS representatives for all meetings. The agenda typically includes updates and issues regarding regional funds for Local Inpatient Purchase of Services (LIPOS), Discharge Assistance Project (DAP) funds, Crisis Stabilization services, Training & Recovery funds, review of the status of admissions ad discharges, assessment of services and resources needs and planning. The RUM Committee monitors the rate of expenditures and whether expenditures adhere to established purposes and procedures.

Currently, the committee's exclusive focus is on the provision of inpatient behavioral health care for adults, ages 18 through 64, although the SBHC may expand utilization management to include inpatient care for child/adolescent and geriatric individuals receiving services at some point in the future.

Management of Admissions and Bed Day Purchase from Private Behavioral Health Providers or Residential Crisis Stabilization Services

Private Inpatient Providers: The three CSBs within Region VI refer individuals to the following private inpatient providers in Virginia:

Within Region VI

- Danville Regional Medical Center (Danville)
- Martinsville Memorial Hospital (Martinsville)

Outside of Region VI

- Carilion St. Alban's Hospital (Radford)
- Carilion Roanoke Memorial Rehab Center (Roanoke)
- Lewis-Gale Hospital (Salem)
- Lewis-Gale Alleghany Regional Hospital (Low Moor)
- Life Center of Galax (Galax)
- Virginia Baptist (Lynchburg)
- New Horizons (Lynchburg)
- Southside Regional Medical Center (Petersburg)
- Poplar Springs Hospital (Petersburg)
- Tucker Pavilion – Chippenham Hospital (Richmond
- John Randolph (Richmond)
- Medical College of Virginia (Richmond)
- St. Mary's Hospital (Richmond)
- Southern Virginia Regional Medical Center (Emporia)
- Pavilion at Williamsburg Place (Williamsburg)
- Snowden-Mary Washington Healthcare (Fredericksburg)

SBHC continues to hold the value of serving individuals receiving services within their communities of residence to the extent possible; thus, those facilities closest to each individual's place of residence will be preferred over those of greater distance.

Use of LIPOS Funds: Local Inpatient Purchase of Services (LIPOS) funds, allocated through DBHDS to Region VI for use by CSBs within the Southside Behavioral Health Consortium, will be used to purchase bed days for individuals admitted for psychiatric treatment at a private inpatient facility. The LIPOS funds will also be used by the CSBs to purchase services for individuals admitted to the Regional Residential Crisis Stabilization program, also known as The Foundation House, which is operated by DPCS, or to other residential crisis stabilization units outside of Region VI, as needed. The purpose of the funds is to divert admission of adult individuals needing emergency care from state psychiatric facilities.

The SBHC will manage, coordinate and monitor LIPOS fund expenditures and will review the effective utilization of the funds. DPCS is the designated fiscal agent to receive the LIPOS funds and to report on expenditures incurred by Region VI. The fiscal agent will allocate amounts of the annual LIPOS funds to the respective CSBs, based on population of the CSBs' service areas. The fiscal agent will disburse funds

to the CSBs on a monthly basis. The RUM Committee will provide oversight of LIPOS utilization on a monthly basis.

Private Inpatient Facilities - Procedures for Using LIPOS Funds

- Bed days may be purchased for individuals who have received a pre-admission screening by a CSB Emergency Services Clinician, who assesses that the individual meets the criteria for admission to a state psychiatric facility.

- Bed days may be purchased for individuals who are involuntarily committed or for those who have court voluntary or voluntary legal status.

- Bed days may be purchased for individuals who reside within the jurisdictions served by the Southside Behavioral Health Consortium.

1. The SBHC or its respective CSBs will negotiate agreements with private inpatient behavioral health care providers to establish set rates per bed day. The SBHC or its respective CSBs will also negotiate for establishing set rates for the attending physicians' fees, when the physicians' fees are separate from the hospital fees.

2. The SBHC will pay the rates for hospital and attending physicians' fees only after all other third party resources have been exhausted for the current hospitalization. LIPOS funds will not be paid for an individual's treatment and care during the period that the individual is being held on a Temporary Detention Order (TDO).

3. The SBHC or its respective CSBs will establish means and procedures to receive billing and remit payments.
4. When an individual has been assessed to meet the criteria for state psychiatric admission by a CSB Emergency Services Clinician, the Clinician will refer the individual for admission to the private behavioral health inpatient unit.

5. If the individual, who lacks insurance coverage for services, is accepted for admission, the Emergency Services Clinician will authorize LIPOS payment for care up to three days, if the individual's admission status is voluntary.

6. If the individual is admitted by Temporary Detention Order and has a subsequent commitment hearing, during which he/she is committed involuntarily or is permitted on a court-ordered voluntary basis by the Special Justice, a CSB Clinician may authorize payment for up to three days of care for the individual, if the individual lack insurance coverage for services.

7. The Behavioral Health Unit of Danville Regional Medical Center will host a weekly Utilization Review Team meeting, comprised minimally of a psychiatrist and case manager of the unit, a DPCS clinical manager, the DPCS Coordinator of Crisis Stabilization Services and the SVMHI Clinical Services Director or designated clinical manager will review the progress of individuals and length of stay. The Team will determine whether each individual is ready for discharge or whether the individual's

condition will stabilize probably within a few additional days so that discharge can occur. If continued stay is indicated, the CSB clinical manager may authorize payment for bed days up to an additional three days, if it is probable that the individual can be discharged within three days.

If the individual is ready for "step-down" level of care and may be transferred to The Foundation House for crisis stabilization or whether the individual requires intermediate or rehabilitative treatment, requiring transfer to SVMHI.

For other private inpatient providers, the attending physician and/or the case manager representing the private inpatient behavioral health unit and a CSB clinical manager will review the individual's progress by the third day of the individual's admission or by the third day after the commitment hearing. The reviewers will determine whether the individual is ready for discharge; whether the consumer meets established criteria for continued stay for acute care (based on Magellan guidelines) or whether the individual is ready for "step-down" level of care and may be transferred to The Foundation House or another residential crisis stabilization services provider or whether the individual requires transfer to SVMHI.

8. If the individual is ready for discharge, the private inpatient behavioral health unit case manager and the CSB discharge liaison will coordinate discharge.

9. If the individual requires intermediate or rehabilitative treatment, the procedures to transfer the individual to SVMHI will be initiated (See *Southside Behavioral Health Consortium – Region VI Protocols for Admissions to Southern Virginia Mental Health Institute*).

10. If the individual meets the criteria for admission to residential crisis stabilization services and is ready for discharge from inpatient services, the behavioral health unit case manager will arrange for the individual's transfer with the coordinator of crisis stabilization services.

11. Authorization to use LIPOS funds to extend length of stay for an individual beyond six days must be approved by the RUM Committee. The CSB clinical manager will consult with the RUM Committee to obtain approval.

Residential Crisis Stabilization Services – Procedures for Using LIPOS Funds

Bed days for residential crisis stabilization services may be purchased for individuals residing in Region VI, who are assessed by CSB clinicians to be in need of crisis intervention but do not require a more restrictive treatment environment that an inpatient facility provides.

1. The SBHC will negotiate the establishment of bed day rates for utilizing the region's residential crisis stabilization services, also known as The Foundation House. Individual CSBs may also negotiate rates with crisis stabilization units operating outside of the Region VI service area, if the CSU is closer to the individual's residence.

2. The SBHC CSBs will utilize LIPOS funds only after all other third party resources have been exhausted and will determine the length of stay for which LIPOS funds will be paid.

3. The SBHC will establish means and procedures to receive billing and remit payments for the purchase of bed days at the Foundation House. The respective CSBs will establish means and procedures to receive billing and remit payments for purchase of bed days from Crisis Stabilization Units outside of Region VI.

4. Referrals to admit an individual for residential crisis stabilization services are made directly to The Foundation House or other residential program. Currently, The Foundation House only admits individuals who are voluntarily requesting admission.

5. If the individual meets criteria for admission but lacks insurance coverage for the service, the CSB Emergency Services Clinician or a clinical manager may authorize a length of stay up to three days, using LIPOS funds.

6. A CSB clinical manager will review the individual's progress with the Coordinator or designee of the Crisis Stabilization Services by the third day of admission. The CSB clinical manager may authorize up to three additional days, using LIPOS funds, if the individual's clinical need indicates that an extended length of stay is necessary.
7. Authorization to use LIPOS funds to extend length of stay for an individual beyond six days must be approved by the RUM Committee. The CSB clinical manager will consult with the RUM Committee to obtain approval.

Management of Admissions and Discharges from SVMHI

The purpose of this function is to ensure that SVMHI is utilized only when lesser restrictive treatment alternatives are not indicated for an individual, due to the level of safety and security required and that the individual will be discharged as rapidly as possible, with adequate supports and resources necessary to sustain their functional skills and abilities in community settings. The role of the RUM Committee will be to identify and monitor data related to admissions and discharges within the region, noting trends so that regional resource needs are recognized. The RUM Committee will set goals for changes necessary to the regional system of care in order to strengthen effectiveness or efficiency of services delivery.

The RUM Committee will also collect incident report data to note deficiencies in compliance with the Regional Admissions Protocols and the statewide Discharge Protocols and will oversee corrective measures necessary to attain compliance.

Admissions and Discharge Data: The Rum Committee gathers monthly data on the following:

- CSB Emergency Services Face-to-Face Contacts: *total number of contacts for crisis intervention and/or pre-admission screening*
- Residential Crisis Stabilization Services: *number of individuals served, number of bed days*
- CSB-referred Admissions for Inpatient Care: *total number of admissions, number referred to private providers, number referred to SVMHI*
- Admissions to private inpatient providers*: numbers admitted to each private provider*
- LIPOS*: number individuals served, number of bed days, amount of funds expended and obligated*
- Admissions to SVMHI*: number admissions by CSB, number of CSB-referred admissions, admissions by Special Court Order, rate of CSB utilization*

- Transfers to SVMHI from private providers: *number by CSB*
- Forensic Admissions: number admitted by Special Court Order and type, number of admitted by Criminal TDO
- Re-admissions Within 30 Days of Discharge: *number re-admitted by CSB, unduplicated number, rate of re-admissions*
- First Episode Admissions: *number of admissions of individuals with no prior admission to a Virginia state facility*
- SVMHI Average Daily Census
- SVMHI Average Length of Stay and Median Length of Stay: *for civil individuals receiving services*
- Discharge Assistance Project: *number of individual plans, total cost of each plan, expenditures for each plan*
- SVMHI Discharges: *number of discharges by CSB, including civil and forensic individuals receiving services*
- Discharges of Individuals with Co-occurring Diagnosis: *number and rate for individuals with mental and substance abuse disorders, number and rate of individuals with mental disorders and intellectual disability*
- Extraordinary Barriers to Discharge*: number of individuals in SVMHI who remain in SVMHI 30 days after they are assessed to be clinically ready for discharge due to significant barriers prohibiting timely discharge to a community setting*

Use of DAP Funds: The RUM Committee will provide oversight for all Discharge Assistance Project (DAP) funds that are allocated to Region VI or to the respective CSBs within the region. DAP funds include *Local DAP*, *Regional DAP* and *New DAP*. Local DAP funds are directly allocated annually by DBHDS to the respective CSBs in the region. Regional DAP funds are allocated annually by DBHDS to Region VI. New DAP funds are allocated to the region by DBHDS based on the total cost of a plan specific to an individual receiving services, minus any entitlement funds or other means to cover the services.

Discharge Procedures: SVMHI and the Region VI CSBs will adhere to the requirements and procedures outlined in the current Statewide Discharge Protocols, which are summarized in the following steps:

1. The SVMHI social worker will notify the case management CSB discharge liaison by the next business day of an admission of an individual. The social worker will provide the discharge liaison/coordinator with the date and time of the individual's Comprehensive Treatment Plan conference. The SVMHI Health Information Management (HIM) department will fax the admission face sheet with the name and phone number of the assigned social worker, as well as the individual's assigned treatment team.
2. The Comprehensive Treatment Plan (CTP) will occur within five calendar days of the individual's admission. The social worker, in collaboration with the treatment team, will complete the Needs Upon Discharge assessment for the individual in the Secure Site Database within one business day of the CTP. Any updates will be entered by the social worker after each of the individual's Treatment Plan Review (TPR) conferences. The social worker will also enter the rating level of the individual's readiness for discharge at the end of the CTP and TPR conferences.
3. The discharge liaison will initiate the Discharge Plan in the Secure Site Database within three business days after the Needs Upon Discharge has been completed. The Discharge Plan will address each need identified in the Needs Upon Discharge.
4. When the individual has achieved the goals identified in his/her treatment plan, the treatment team will determine clinical readiness for discharge. The social worker will notify the discharge liaison/coordinator of the individual's clinical readiness for discharge within one business day.

5. The discharge liaison will finalize discharge planning for the individual as soon as possible but within ten business days of the notification. The social worker and the treatment team will collaborate with the discharge liaison to finalize the plan, including setting the exact day of discharge. The CSB will be responsible for arranging the transportation of the individual to the location he/she will reside after discharge. The social worker will ensure the individual follow-up appointments made with the individual's primary health care provider for any medical needs. The discharge liaison will arrange for the CSB intake appointment and the psychiatrist appointment within fourteen days of discharge.
6. The social worker will facilitate the completion of the *Discharge Information and Instructions DBH Form #226* by the treatment team within twenty-four hours of the individual's scheduled discharge, which will be reviewed with the individual. The Form #226 will be forwarded to the CSB or other next level of care within one business day of the discharge.
7. The SVMHI team psychiatrist will complete a discharge summary and it will be forwarded to the CSB within fourteen days of discharge, in order for it to be reviewed by the CSB psychiatrist prior the individual's appointment.

During the course of the individual's inpatient stay, barriers to discharge may emerge. Once identified, the CSB will determine whether DAP funds can be used to address all or a part of them. If so, designated CSB staff will develop a DAP plan for the individual to purchase resources and/or services that will enable community transition and sustained ability to remain in a community residential setting.

The CSB Behavioral Health Director will present the individual's DAP plan for approval by the RUM Committee members at the regularly scheduled meeting of the RUM Committee. The DAP plan is forwarded to the Regional Data Technician, who maintains a file of all active DAP plans.

DAP plans will be presented to the RUM Committee for scheduled review and for any updates on a quarterly basis. Quarterly reports to DBHDS will be submitted in accordance with the statewide *Discharge Assistance Project Administrative Manual* policy and procedures.

If the barriers prevent an individual's discharge within thirty days of the notification of clinical readiness for discharge, the CSB discharge liaison will complete the *Extraordinary Barriers to Discharge Form (DBH 1192)* in the Secure Site Database. SVMHI will maintain a list of individuals who have been assessed clinically ready for discharge, also noting those who have extraordinary barriers to discharge.

Community Transition Teams

Each CSB in the region convenes a regular monthly community transition team meeting at the respective CSB locations. The members of each team include the behavioral health director, director of community support services, case management coordinator, discharge liaison, the forensic coordinator, the SVMHI director of clinical services and the SVMHI forensic social worker. Other CSB program managers and the SVMHI forensic coordinator may attend, depending on the community transition needs, on the services proposed for individuals' post-discharge return to the community or if there are difficulties in the planning process.

The meeting agenda will include:

- Thorough review of the current status of each of the individuals who are ready for discharge, including efforts and progress toward eliminating any barriers to discharge;
- Review of each individual who is included on the extraordinary barriers list, developing strategies to resolve the situations impeding the individual's progression toward successful discharge.
- Review of circumstances of individuals who have had readmissions within 30 days of the last facility discharge and those consumers who have had multiple admissions within a period of a year;

- Review of the progress of individuals with forensic status, particularly those who have Not Guilty by Reason of Insanity (NGRI) status to plan for their respective community transition and conditional release.

The Regional Data Technician will record minutes of each meeting, which will be reviewed at the following meeting and kept on file.

Regional Partnerships

The purpose of this function of utilization management is to establish continuing, dynamic partnerships with private inpatient care providers, other community services providers, hospital emergency departments, police and sheriff departments, magistrates and other parties who are involved in admissions or discharge processes. The members of partnerships are focused on issues concerning continuity of care, transfer of care and streamlining procedures for admissions and discharges, increasing utilization of residential crisis stabilization and resolving systemic difficulties.

The Regional Data Technician distributes meeting notices and the meeting agenda. Minutes are recorded for each meeting and kept on file.

The Danville- Pittsylvania Partnership meets monthly on the first Thursday. Members include the:

- SVMHI facility director,
- SVMHI clinical services director,
- SVMHI medical director,
- DPCS behavioral health director,
- DPCS clinical services director,
- DRMC Behavioral Health Services director,
- DRMC social worker/case manager.

The Piedmont Partnership meets monthly on the second Wednesday. Its members include the:

- PCS behavioral health director,
- PCS clinical services director,
- PCS emergency services coordinator,
- PCS Lead ES clinicians for Patrick and Franklin Counties,
- PCS discharge liaisons,
- Martinsville Memorial Hospital Psychiatric Services director,
- MMH Psychiatric Services case manager,
- MMH emergency response team clinician,
- SVMHI clinical services director.
- MMH Chief Security Officer

PCS includes the City of Martinsville and the counties of Henry, Patrick and Franklin.

Danville-Pittsylvania Joint Emergency Services meets bi-monthly on the third Tuesday. Members include the:

- SVMHI clinical services director,
- SVMHI medical director
- DPCS behavioral health director,
- DPCS clinical services director
- DPCS Emergency Services Coordinator
- DPCS Residential Crisis Stabilization Services Coordinator
- DRMC Behavioral Health Services director,

- DRMC Behavioral Health Services medical director
- DRMC social worker/case manager.
- DRMC Emergency Department Director
- DRMC ED Medical Director
- Crisis Intervention Team (CIT) Coordinator
- Danville Police Department representative
- Danville City Sheriff and officers of the department
- Pittsylvania County Sheriff's Department representatives
- Chief Magistrate

Piedmont Joint Emergency Services meets bi-monthly on the second Thursday. Members include the:

- PCS behavioral health director,
- PCS clinical services director,
- PCS emergency services coordinator,
- PCS Lead ES clinicians for Patrick and Franklin Counties
- PCS discharge liaisons
- Martinsville Memorial Hospital Psychiatric Services director,
- MMH Psychiatric Services case manager,
- MMH emergency response team clinician,
- SVMHI clinical services director.
- MMH Emergency Department Director
- CIT Coordinator
- Martinsville City Sheriff
- Henry County Sheriff's Department representative
- Patrick County Sheriff's Department representative
- MMH Chief Security Officer
- Chief Magistrates

The members represent Martinsville City and counties of Henry and Patrick.

Franklin County Joint Emergency Services meets quarterly on the first Thursday. Members include the:

- PCS-Franklin clinic manager
- PCS Lead ES clinician
- Carilion Franklin Memorial ED director
- Carilion Franklin Memorial medical director
- Franklin County Sheriff
- SVMHI clinical director
- SVMHI medical director
- Chief Magistrates

Southside Partnership/Joint Emergency Services meets bi-monthly on the third Thursday. Its members include the:

- Southside Community Services (SCS) Executive Director
- SCS behavioral health director
- SCS emergency services coordinator
- SCS discharge liaison

- ED director for Halifax Regional Hospital (South Boston)
- ED director for Southside Community Memorial Hospital (South Hill)
- Halifax County Sheriff's Department representative
- Mecklinburg County Sheriff's Department representative
- Brunswick County Sheriff's Department representative
- South Boston Police Department representative
- CIT coordinator
- SVMHI clinical services director

Management of the Clinical Course of Treatment and Length of Stay at SVMHI

SVMHI will continuously monitor the efficacy of treatment interventions and the efficient allocation of its internal resources in order to provide excellent quality of care, while minimizing individuals' length of stay.

SVMHI employs a utilization review coordinator who performs the following functions:

- Reviews each admission when the individual is covered by Medicare or other health insurance, when the individual is under 21 years old and covered by Medicaid and every fifth admission when the individual has no insurance coverage to determine whether the individual's circumstances, at the time of his/her admission, met the criteria for medical necessity for inpatient care.

- Conducts reviews of individuals who are re-admitted within thirty days of the last discharge from SVMHI, individuals re-admitted within ninety days of the last discharge and individuals re-admitted to SVMHI three times within a year. The reviews consider multiple factors that may have contributed to the necessity for re-admission.

- When the individual's acute care stay is covered by Medicare, the utilization review coordinator will conduct scheduled reviews of the individual's continued stay. When a review indicates that the individual no longer meets the criteria for acute care, based on the Magellan criteria for continued stay, the attending psychiatrist will be notified. The psychiatrist may appeal the determination and, if appealed, the medical director will hear the appeal. If the psychiatrist accepts the determination, the individual will either be assessed to be clinically ready for discharge or assessed to require intermediate inpatient rehabilitative treatment. In either case, the individual will have non-acute status until discharged from the facility.

- Conducts reviews of individuals' course of treatment that have been treated for forty-five days and have not been assessed to be clinically ready for discharge. When a review indicates that the individual no longer meets criteria for continued stay, based on Magellan criteria for continued stay, the medical director and the attending psychiatrist will be notified. If the individual continues to meet the criteria for continued stay, the utilization review coordinator will schedule a multidisciplinary case consultation with the attending psychiatrist, who will invite key clinical staff, leadership staff and pharmacist to determine whether any changes in the treatment regimen may be indicated to improve the individual's progression to clinical stability. The multidisciplinary case consultation will consider if there are barriers to clinical stability and to affirm that all appropriate therapeutic measures and protocols are being applied to hasten

clinical stability and discharge readiness. The attending psychiatrist will enter a summary of the consultation in the individual's medical record and forward a copy of the summary to the utilization review coordinator. After the individual has been in treatment for forty-five days and more, the utilization review coordinator will subsequently review the individual's progress monthly until the individual's discharge.

- The utilization review coordinator will schedule monthly meetings of the SVMHI Utilization Management Committee, comprised of the utilization review coordinator, medical director, psychiatrists, director of nursing, facility administrator, clinical services director, and director of social work. The agenda includes:

    1. Reports of the reviews for medical necessity of admissions during the previous month,
    2. Reviews of re-admissions,
    3. Reviews of individuals' length of stay exceeding forty-five days,
    4. Results of multidisciplinary case consultations,
    5. Review of the barriers to discharge of individuals on the Extraordinary Barriers to Discharge list and the progress made to resolve the barriers,
    6. Referrals to the regional residential crisis stabilization services
    7. Special focus studies
    8. RUM Committee report
    9. Other issues related to utilization management

The RUM Committee will review the Regional Utilization Management Plan during the fourth quarter of each fiscal year. Recommendations for amendments will be submitted to the SBHC for review and approval.

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The SBHC approved the Protocols for Admissions to SVMHI and the Regional Utilization Management Plan on this day, _____, 2014.

_____ _____

Jim Bebeau, Executive Director
Danville-Pittsylvania Community Services
SBHC Chairperson

Jim Tobin, Executive Director,
Piedmont Community Services

_____ _____

Don Burge, Executive Director
Southside Community Services

Daniel L. Herr, Facility Director
Southern Virginia mental Health Institute

PARTNERSHIP PLANNING REGION VII ADMISSION PROTOCOL

The following processes are followed during assessment, referral, and inpatient admission of individuals experiencing a psychiatric crisis and in need of a TDO, with the underlying principle that the individual is the most important part of the process and deserves the right treatment, in the right setting, at the right time, improving his/her chances for recovery, as well as the individual's safety and that of the public. Individual client circumstances and clinician judgment of appropriate placements make each emergency assessment unique.

Accessing a psychiatric bed for a TDO:

- Once the CSB Emergency Services (ES) clinician has completed the assessment and determined that a TDO is needed, the Psychiatric Bed Registry is reviewed for information to assist in determining bed availability. If the individual is currently at a hospital, medical screening is requested at the time of assessment.

- CSB Emergency Services clinicians consider the possible appropriateness of CSU before calling local hospitals. Exclusion criteria for CSU would be acute suicidal ideation with clear intent, aggressive acting out behaviors, being acutely psychotic, posing a significant flight risk, and refusing treatment. Following review of all of the information received from the prescreener, CSU calls the doctor on call for medical clearance for admission. CSU can be optimally utilized for stepdowns from both state and acute care facilities.

- If CSU is not appropriate, Connect or RESPOND® are contacted; the first call is usually dependent on which hospital is currently serving the client. For both CSBs, a local bed is always preferable.

    - Connect and RESPOND® will review all information on the patient if there are available beds, before discussing the admission with the physician. They emphasize the safety of the individual with regard to all medical issues. If a bed is available, the attending physician makes the decision regarding admission.
    - If the individual is accepted for hospital admission, Connect or RESPOND® calls the unit for a bed assignment and contacts the CSB with bed information.
    - If there are no beds available or admission denied, the ES clinician is notified by Connect or RESPOND®.
    - Except in extenuating circumstances, hospitals will respond with acceptance or denial of the admission within 20-30 minutes from call by the ES clinician.

- If there are no beds at LewisGale Behavioral Health or Carilion Psychiatry, the ES clinician begins making calls for an available bed outside the region, with no more than 5-10 minutes between calls. Multiple bed placements can be pursued simultaneously. The list of primary and secondary hospitals which can be called are attached as Addendum A of this protocol.

- Admission to the Salem VA Medical Center can be considered for qualifying veterans. The VA will review ECO/TDOs during work hours (M-F 8-4:30). If the individual is already in a bed, they will accept after the hearing if it is an appropriate admission.

- Deaf or hearing impaired individuals will be treated as any other individual without discrimination and Western State Hospital may be considered if the individual knows ASL.

- For individuals with confirmed or suspected intellectual disability, the ES clinician will contact REACH (formerly START) for crisis response, consultation, and resources at 1-855-887-8278.

- No later than hour 3 of an ECO, or at hour 3 of the prescreening process when a TDO is being pursued without an ECO, the emergency services clinician will give a "heads up" call to the Catawba Director of Social Work during regular business hours or to the Nursing Supervisor after hours/weekends. This process applies to both adult and geriatric admissions.

    - Information relayed will include the fact that a TDO bed is being pursued but has not yet been obtained and there is a possibility that a safety net bed at a State Hospital might be needed. At that time, relevant client information/prescreening form will be also faxed to Catawba. This call should be made even earlier if the clinician has the needed information and perceives that there might be a bed issue.
    - At that time, Catawba will begin immediate review of the information faxed for any additional medical considerations/testing which may be needed. The Catawba physician reviews for medical clearance. The Nursing Supervisor also looks at the information for any potential nursing issues. If there are medical clearance issues, the Catawba physician contacts the ER physician to discuss. If there are any problems, the Catawba Chief of Staff is notified. After hours, the Nursing Supervisor calls the social worker on call to review the information.
    - Following this heads up call to Catawba, the ES clinician will continue to pursue alternative bed placement at other facilities. If other facility placements appear more likely, the approval process is not completed beyond the initial call and review of faxed prescreening until the follow-up call from the CSB at 4.5 hours.

- An ECO extension is obtained prior to the expiration of the 4 hour ECO and the ES clinician continues to make additional calls to facilities for possible admission. If, at hour 4.5, another placement has not been found and a safety net bed is needed for either an adult or geriatric individual, the ES clinician will contact his/her supervisor, who will contact the CSB Mental Health Director or designee, who will then contact the Catawba Director, or designee, to secure a safety net bed.
    - Once the Catawba Director/designee is notified, the approval process for a bed at Catawba continues, with review by the physician and nursing supervisor.
    - The Social Work Director during the day or the Nursing Supervisor afterhours notifies the CSB of acceptance.
- If no safety net bed is available at Catawba, the Hospital Director contacts other State facilities for possible placement.

Medical Screening:

- The region appreciates the clinical, legal and ethical importance of medical screening to eliminate possible medical causes for a person's presenting psychiatric symptoms and signs. As there are a number of rapidly lethal medical conditions that may manifest common psychiatric symptoms, the ability to identify these conditions and make appropriate early interventions is vital. A wide range of medical conditions and treatments may result in abnormal behavior, and many medical disorders may produce or exacerbate psychiatric symptoms in patients with pre-existing mental illness. Failure to detect and diagnose underlying medical disorders may result in significant and unnecessary morbidity and mortality, invasion of an individual's life and constitutionally guaranteed liberties, and liability to community systems and transferring physicians. Transfer of patients with acute or unstable medical conditions from a local hospital to a state facility may constitute a violation of the *Comprehensive Omnibus Budget Reconciliation Act (COBRA) of 1996* (as revised) and the *Emergency Medical Treatment and Active Labor Act (EMTALA)*. CSB's should have the capability to divert individuals with acute

medical conditions who do not meet facility admission criteria to appropriate medical facilities. Individuals whose medical assessments indicate the presence of an acute or unstable medical condition must be referred by the CSB for immediate treatment in an appropriate medical facility.

- The reason that the patient presents in the ED guides the scope of the medical screening. Additional medical screening tests requested by a potential admitting facility may impact the timeline of the process. Communication with physicians is key for making the right decisions with all available medical information.

Transfers and Discharge Planning:

- If an individual is placed in a State facility outside of the region, the CSB of origin will work to get the patient back to this area as soon as possible. The CSB communicates with the out of region State facility, obtains patient information, and works with Catawba or CSU to set up the transfer. The patient would likely not be transferred if he/she were going to be released at the hearing or shortly thereafter.
- Transfers from a private hospital to Catawba are coordinated through the regional Census Management Team (CMT). Individuals are considered for CMT discussion if they need a more intensive level of in-patient care.
- CMT does <u>not</u> discuss the following:
    - Voluntary admissions
    - Geriatric admissions.
    - Individuals on medical units who have not been TDO'd.
    - Admitted patients prior to the TDO hearing will not be discussed, <u>*except*</u> in the following situation:
        iv. Person is a known consumer of services
        v. The hearing is being held that day and staff is certain the patient will be committed.
        vi. Based on knowledge of person and acuity of current symptoms, the patient requires a different level of care than is currently being provided.
- Based on presentation of patients, the CMT members then discuss the appropriate level of care needed for the individual. They will prioritize based on acuity of patient symptoms for level of care needed and available beds.
- Documentation typically required for transfer from private facility to Catawba includes:
    - The most recent CSB prescreening
    - Current commitment papers
    - History and Physical
    - Medication list
    - Labs (whatever has been done – usually CBC, CMP, UDS)
    - Vitals
    - EKG and chest X-Ray, if they have been done
    - Notes (physician, nursing, social work)

Utilization Management:

- The region will develop a coordinated process for regional utilization management that will focus on patient flow metrics, i.e., admissions, discharges, number of TDOs, insured/uninsured issues, extraordinary barriers list, and overall bed utilization. This group will consist of current members of CMT, as well as State Hospital discharge planners, CSB emergency service representatives, Connect and Respond representatives, CSB Mental Health Directors, and

Catawba Chief of Staff. It is important that both the admission and discharge clinicians work together with the ability to expand patient diversions.

- Information on expired TDOs is to be sent to the Regional Manager by the next business day. The Regional Manager will report this information to DBHDS as directed.

ADDENDUM A-PPR 7 Primary and Secondary Hospital List (attached)

REGION XIII

Southside Behavioral Health Consortium Utilization Management Plan
Behavioral Health Care of Adult Individuals Receiving Services
In Inpatient or Residential Settings
March 10, 2014

Purpose and Function

The Southside Behavioral Health Consortium (SBHC) is committed to providing recovery-oriented inpatient care and other effective community-based behavioral health interventions in the safest, least restrictive environments possible, optimally utilizing the various resources available within the Southside region. Ten objectives are established to better fulfill this goal:

- To strengthen the continuity of care for individuals receiving services through collaborative endeavors between private and public care providers, responding to individuals' levels of need with appropriate levels of care;

- To strengthen the procedural aspects of behavioral health services delivery toward creating a seamless system of care within the SBHC services areas.

- To serve individuals receiving services within their community of residence to the extent possible;

- To respect individuals' preferences to the extent possible and appropriate when psychiatric interventions are indicated;

- To maximize utilization of private, inpatient behavioral health providers for individuals requiring intensive care for acute conditions;

- To utilize the regional residential crisis stabilization services, operated by Danville-Pittsylvania Community Services, for individuals whose crises can be resolved in a lesser restrictive treatment environment than inpatient services provides;

- To maximize utilization of Southern Virginia Mental Health Institute (SVMHI) for individuals requiring intermediate care and psychosocial rehabilitation;

- To ensure timely and cost effective means of delivering inpatient psychiatric care;

- To maintain a census at SVMHI at or below funded levels (up to 48 certified beds and 24 non-certified beds);

- To manage the discharges of individuals from inpatient settings to their home environments as rapidly as possible, with necessary community supports mobilized to promote ongoing stability for them as they live in the community setting of their choice.

Utilization management is a functional process integral to fulfilling the goals and objectives set forth by the Southside Behavioral Health Consortium. Four strategic functions will be implemented to achieve objectives:

5. *Management of admissions and bed day purchases from private behavioral health providers;*
6. *Management of admissions and discharges from SVMHI;*
7. *Regional Partnerships*
8. *Management of the clinical course of treatment and length of stay at SVMHI*

Regional Utilization Management Committee: The SBHC will maintain the established Regional Utilization Management Committee (RUM). The RUM Committee will oversee the application of the four utilization management functions, establish goals and strategies to achieve them, with empirical outcome measures, identify and collect data pertinent to utilization management, prepare regular reports to the SBHC and provide recommendations to the SBHC for operational changes as needed.

The committee is comprised of the following members:

- The SVMHI Director of Clinical Services, who serves as the Consortium's designated Regional Project Manager for Region VI, which is the SBHC services area.
- Behavioral Health Directors of Danville-Pittsylvania Community Services (DPCS), Southside Community Services(SCS) and Piedmont Community Services (PCS)
- The DPCS Director of Finance (DPCS is the SBHC fiscal agent for regional funds)
- Behavioral health finance managers for DPCS, SCS and PCS

DPCS, SCS, PCS and SVMHI contribute administrative funds to support the position of Regional Data Technician, employed by SVMHI, to provide administrative assistance to the RUM Committee.

The RUM Committee meets on the fourth Monday of each month and at other times as required to conduct business. The committee welcomes the attendance and participation of DBHDS representatives for all meetings. The agenda typically includes updates and issues regarding regional funds for Local Inpatient Purchase of Services (LIPOS), Discharge Assistance Project (DAP) funds, Crisis Stabilization services, Training & Recovery funds, review of the status of admissions ad discharges, assessment of services and resources needs and planning. The RUM Committee monitors the rate of expenditures and whether expenditures adhere to established purposes and procedures.

Currently, the committee's exclusive focus is on the provision of inpatient behavioral health care for adults, ages 18 through 64, although the SBHC may expand utilization management to include inpatient care for child/adolescent and geriatric individuals receiving services at some point in the future.

Management of Admissions and Bed Day Purchase from Private Behavioral Health Providers or Residential Crisis Stabilization Services

Private Inpatient Providers
The three CSBs within Region VI refer individuals to the following private inpatient providers in Virginia:

<u>Within Region VI</u>

- Danville Regional Medical Center (Danville)
- Martinsville Memorial Hospital (Martinsville)

Outside of Region VI

- Carilion St. Alban's Hospital (Radford)
- Carilion Roanoke Memorial Rehab Center (Roanoke)
- Lewis-Gale Hospital (Salem)
- Lewis-Gale Alleghany Regional Hospital (Low Moor)
- Life Center of Galax (Galax)
- Virginia Baptist (Lynchburg)
- New Horizons (Lynchburg)
- Southside Regional Medical Center (Petersburg)
- Poplar Springs Hospital (Petersburg)
- Tucker Pavilion – Chippenham Hospital (Richmond
- John Randolph (Richmond)
- Medical College of Virginia (Richmond)
- St. Mary's Hospital (Richmond)
- Southern Virginia Regional Medical Center (Emporia)
- Pavilion at Williamsburg Place (Williamsburg)
- Snowden-Mary Washington Healthcare (Fredericksburg)

SBHC continues to hold the value of serving individuals receiving services within their communities of residence to the extent possible; thus, those facilities closest to each individual's place of residence will be preferred over those of greater distance.

Use of LIPOS Funds

Local Inpatient Purchase of Services (LIPOS) funds, allocated through DBHDS to Region VI for use by CSBs within the Southside Behavioral Health Consortium, will be used to purchase bed days for individuals admitted for psychiatric treatment at a private inpatient facility. The LIPOS funds will also be used by the CSBs to purchase services for individuals admitted to the Regional Residential Crisis Stabilization program, also known as The Foundation House, which is operated by DPCS, or to other residential crisis stabilization units outside of Region VI, as needed. The purpose of the funds is to divert admission of adult individuals needing emergency care from state psychiatric facilities.

The SBHC will manage, coordinate and monitor LIPOS fund expenditures and will review the effective utilization of the funds. DPCS is the designated fiscal agent to receive the LIPOS funds and to report on expenditures incurred by Region VI. The fiscal agent will allocate amounts of the annual LIPOS funds to the respective CSBs, based on population of the CSBs' service areas. The fiscal agent will disburse funds to the CSBs on a monthly basis. The RUM Committee will provide oversight of LIPOS utilization on a monthly basis.

Private Inpatient Facilities - Procedures for Using LIPOS Funds

- Bed days may be purchased for individuals who have received a pre-admission screening by a CSB Emergency Services Clinician, who assesses that the individual meets the criteria for admission to a state psychiatric facility.

- Bed days may be purchased for individuals who are involuntarily committed or for those who have court voluntary or voluntary legal status.

- Bed days may be purchased for individuals who reside within the jurisdictions served by the Southside Behavioral Health Consortium.

12. The SBHC or its respective CSBs will negotiate agreements with private inpatient behavioral health care providers to establish set rates per bed day. The SBHC or its respective CSBs will also negotiate for establishing set rates for the attending physicians' fees, when the physicians' fees are separate from the hospital fees.

13. The SBHC will pay the rates for hospital and attending physicians' fees only after all other third party resources have been exhausted for the current hospitalization. LIPOS funds will not be paid for an individual's treatment and care during the period that the individual is being held on a Temporary Detention Order (TDO).

14. The SBHC or its respective CSBs will establish means and procedures to receive billing and remit payments.

15. When an individual has been assessed to meet the criteria for state psychiatric admission by a CSB Emergency Services Clinician, the Clinician will refer the individual for admission to the private behavioral health inpatient unit.

16. If the individual, who lacks insurance coverage for services, is accepted for admission, the Emergency Services Clinician will authorize LIPOS payment for care up to three days, if the individual's admission status is voluntary.

17. If the individual is admitted by Temporary Detention Order and has a subsequent commitment hearing, during which he/she is committed involuntarily or is permitted on a court-ordered voluntary basis by the Special Justice, a CSB Clinician may authorize payment for up to three days of care for the individual, if the individual lack insurance coverage for services.

18. The Behavioral Health Unit of Danville Regional Medical Center will host a weekly Utilization Review Team meeting, comprised minimally of a psychiatrist and case manager of the unit, a DPCS clinical manager, the DPCS Coordinator of Crisis Stabilization Services and the SVMHI Clinical Services Director or designated clinical manager will review the progress of individuals and length of stay. The Team will determine whether each individual is ready for discharge or whether the individual's condition will stabilize probably within a few additional days so that discharge can occur. If continued stay is indicated, the CSB clinical manager may authorize payment for bed days up to an additional three days, if it is probable that the individual can be discharged within three days.

    If the individual is ready for "step-down" level of care and may be transferred to The Foundation House for crisis stabilization or whether the individual requires intermediate or rehabilitative treatment, requiring transfer to SVMHI.

    For other private inpatient providers, the attending physician and/or the case manager representing the private inpatient behavioral health unit and a CSB clinical manager will review the individual's progress by the third day of the individual's admission or by the third day after the commitment hearing. The reviewers will determine whether the individual is ready for discharge; whether the consumer meets established criteria for continued stay for acute care (based on Magellan guidelines) or whether the individual is ready for "step-down" level of care and may be transferred to The Foundation House or another residential crisis stabilization services provider or whether the individual requires transfer to SVMHI.

19. If the individual is ready for discharge, the private inpatient behavioral health unit case manager and the CSB discharge liaison will coordinate discharge.

20. If the individual requires intermediate or rehabilitative treatment, the procedures to transfer the individual to SVMHI will be initiated (See *Southside Behavioral Health Consortium – Region VI Protocols for Admissions to Southern Virginia Mental Health Institute*).

21. If the individual meets the criteria for admission to residential crisis stabilization services and is ready for discharge from inpatient services, the behavioral health unit case manager will arrange for the individual's transfer with the coordinator of crisis stabilization services.

22. Authorization to use LIPOS funds to extend length of stay for an individual beyond six days must be approved by the RUM Committee. The CSB clinical manager will consult with the RUM Committee to obtain approval.

Residential Crisis Stabilization Services – Procedures for Using LIPOS Funds

Bed days for residential crisis stabilization services may be purchased for individuals residing in Region VI, who are assessed by CSB clinicians to be in need of crisis intervention but do not require a more restrictive treatment environment that an inpatient facility provides.

8. The SBHC will negotiate the establishment of bed day rates for utilizing the region's residential crisis stabilization services, also known as The Foundation House. Individual CSBs may also negotiate rates with crisis stabilization units operating outside of the Region VI service area, if the CSU is closer to the individual's residence.

9. The SBHC CSBs will utilize LIPOS funds only after all other third party resources have been exhausted and will determine the length of stay for which LIPOS funds will be paid.

10. The SBHC will establish means and procedures to receive billing and remit payments for the purchase of bed days at the Foundation House. The respective CSBs will establish means and procedures to receive billing and remit payments for purchase of bed days from Crisis Stabilization Units outside of Region VI.

11. Referrals to admit an individual for residential crisis stabilization services are made directly to The Foundation House or other residential program. Currently, The Foundation House only admits individuals who are voluntarily requesting admission.

12. If the individual meets criteria for admission but lacks insurance coverage for the service, the CSB Emergency Services Clinician or a clinical manager may authorize a length of stay up to three days, using LIPOS funds.

13. A CSB clinical manager will review the individual's progress with the Coordinator or designee of the Crisis Stabilization Services by the third day of admission. The CSB clinical manager may authorize up to three additional days, using LIPOS funds, if the individual's clinical need indicates that an extended length of stay is necessary.

14. Authorization to use LIPOS funds to extend length of stay for an individual beyond six days must be approved by the RUM Committee. The CSB clinical manager will consult with the RUM Committee to obtain approval.

Management of Admissions and Discharges from SVMHI

The purpose of this function is to ensure that SVMHI is utilized only when lesser restrictive treatment alternatives are not indicated for an individual, due to the level of safety and security required and that the individual will be discharged as rapidly as possible, with adequate supports and resources necessary to sustain their functional skills and abilities in community settings. The role of the RUM Committee will be to identify and monitor data related to admissions and discharges within the region, noting trends so that regional resource needs are recognized. The RUM Committee will set goals for changes necessary to the regional system of care in order to strengthen effectiveness or efficiency of services delivery.

The RUM Committee will also collect incident report data to note deficiencies in compliance with the Regional Admissions Protocols and the statewide Discharge Protocols and will oversee corrective measures necessary to attain compliance.

Admissions and Discharge Data: The Rum Committee gathers monthly data on the following:

- CSB Emergency Services Face-to-Face Contacts: *total number of contacts for crisis intervention and/or pre-admission screening*
- Residential Crisis Stabilization Services: *number of individuals served, number of bed days*
- CSB-referred Admissions for Inpatient Care: *total number of admissions, number referred to private providers, number referred to SVMHI*
- Admissions to private inpatient providers*: numbers admitted to each private provider*
- LIPOS*: number individuals served, number of bed days, amount of funds expended and obligated*
- Admissions to SVMHI*: number admissions by CSB, number of CSB-referred admissions, admissions by Special Court Order, rate of CSB utilization*
- Transfers to SVMHI from private providers: *number by CSB*
- Forensic Admissions: number admitted by Special Court Order and type, number of admitted by Criminal TDO
- Re-admissions Within 30 Days of Discharge: *number re-admitted by CSB, unduplicated number, rate of re-admissions*
- First Episode Admissions: *number of admissions of individuals with no prior admission to a Virginia state facility*
- SVMHI Average Daily Census
- SVMHI Average Length of Stay and Median Length of Stay: *for civil individuals receiving services*
- Discharge Assistance Project: *number of individual plans, total cost of each plan, expenditures for each plan*
- SVMHI Discharges: *number of discharges by CSB, including civil and forensic individuals receiving services*
- Discharges of Individuals with Co-occurring Diagnosis: *number and rate for individuals with mental and substance abuse disorders, number and rate of individuals with mental disorders and intellectual disability*
- *Extraordinary Barriers to Discharge: number of individuals in SVMHI who remain in SVMHI 30 days after they are assessed to be clinically ready for discharge due to significant barriers prohibiting timely discharge to a community setting*

Use of DAP Funds

The RUM Committee will provide oversight for all Discharge Assistance Project (DAP) funds that are allocated to Region VI or to the respective CSBs within the region. DAP funds include *Local DAP*, *Regional DAP* and *New DAP*. Local DAP funds are directly allocated annually by DBHDS to the respective CSBs in the region. Regional DAP funds are allocated annually by DBHDS to Region VI. New DAP funds are allocated to the region by DBHDS based on the total cost of a plan specific to an individual receiving services, minus any entitlement funds or other means to cover the services.

Discharge Procedures: SVMHI and the Region VI CSBs will adhere to the requirements and procedures outlined in the current Statewide Discharge Protocols, which are summarized in the following steps:

8. The SVMHI social worker will notify the case management CSB discharge liaison by the next business day of an admission of an individual. The social worker will provide the discharge liaison/coordinator with the date and time of the individual's Comprehensive Treatment Plan conference. The SVMHI Health Information Management (HIM) department will fax the admission face sheet with the name and phone number of the assigned social worker, as well as the individual's assigned treatment team.
9. The Comprehensive Treatment Plan (CTP) will occur within five calendar days of the individual's admission. The social worker, in collaboration with the treatment team, will complete the Needs Upon Discharge assessment for the individual in the Secure Site Database within one business day of the CTP. Any updates will be entered by the social worker after each of the individual's Treatment Plan Review (TPR) conferences. The social worker will also enter the rating level of the individual's readiness for discharge at the end of the CTP and TPR conferences.
10. The discharge liaison will initiate the Discharge Plan in the Secure Site Database within three business days after the Needs Upon Discharge has been completed. The Discharge Plan will address each need identified in the Needs Upon Discharge.
11. When the individual has achieved the goals identified in his/her treatment plan, the treatment team will determine clinical readiness for discharge. The social worker will notify the discharge liaison/coordinator of the individual's clinical readiness for discharge within one business day.
12. The discharge liaison will finalize discharge planning for the individual as soon as possible but within ten business days of the notification. The social worker and the treatment team will collaborate with the discharge liaison to finalize the plan, including setting the exact day of discharge. The CSB will be responsible for arranging the transportation of the individual to the location he/she will reside after discharge. The social worker will ensure the individual follow-up appointments made with the individual's primary health care provider for any medical needs. The discharge liaison will arrange for the CSB intake appointment and the psychiatrist appointment within fourteen days of discharge.
13. The social worker will facilitate the completion of the *Discharge Information and Instructions DBH Form #226* by the treatment team within twenty-four hours of the individual's scheduled discharge, which will be reviewed with the individual. The Form #226 will be forwarded to the CSB or other next level of care within one business day of the discharge.
14. The SVMHI team psychiatrist will complete a discharge summary and it will be forwarded to the CSB within fourteen days of discharge, in order for it to be reviewed by the CSB psychiatrist prior the individual's appointment.

During the course of the individual's inpatient stay, barriers to discharge may emerge. Once identified, the CSB will determine whether DAP funds can be used to address all or a part of them. If so, designated CSB staff will develop a DAP plan for the individual to purchase resources and/or services that will enable community transition and sustained ability to remain in a community residential setting.

The CSB Behavioral Health Director will present the individual's DAP plan for approval by the RUM Committee members at the regularly scheduled meeting of the RUM Committee. The DAP plan is forwarded to the Regional Data Technician, who maintains a file of all active DAP plans.

DAP plans will be presented to the RUM Committee for scheduled review and for any updates on a quarterly basis. Quarterly reports to DBHDS will be submitted in accordance with the statewide *Discharge Assistance Project Administrative Manual* policy and procedures.

If the barriers prevent an individual's discharge within thirty days of the notification of clinical readiness for discharge, the CSB discharge liaison will complete the *Extraordinary Barriers to Discharge Form (DBH 1192)* in the Secure Site Database. SVMHI will maintain a list of individuals who have been assessed clinically ready for discharge, also noting those who have extraordinary barriers to discharge.

Community Transition Teams

Each CSB in the region convenes a regular monthly community transition team meeting at the respective CSB locations. The members of each team include the behavioral health director, director of community support services, case management coordinator, discharge liaison, the forensic coordinator, the SVMHI director of clinical services and the SVMHI forensic social worker. Other CSB program managers and the SVMHI forensic coordinator may attend, depending on the community transition needs, on the services proposed for individuals' post-discharge return to the community or if there are difficulties in the planning process.

The meeting agenda will include:

- Thorough review of the current status of each of the individuals who are ready for discharge, including efforts and progress toward eliminating any barriers to discharge;
- Review of each individual who is included on the extraordinary barriers list, developing strategies to resolve the situations impeding the individual's progression toward successful discharge.
- Review of circumstances of individuals who have had readmissions within 30 days of the last facility discharge and those consumers who have had multiple admissions within a period of a year;
- Review of the progress of individuals with forensic status, particularly those who have Not Guilty by Reason of Insanity (NGRI) status to plan for their respective community transition and conditional release.

The Regional Data Technician will record minutes of each meeting, which will be reviewed at the following meeting and kept on file.

Regional Partnerships

The purpose of this function of utilization management is to establish continuing, dynamic partnerships with private inpatient care providers, other community services providers, hospital emergency departments, police and sheriff departments, magistrates and other parties who are involved in admissions or discharge processes. The members of partnerships are focused on issues concerning continuity of care, transfer of care and streamlining procedures for admissions and discharges, increasing utilization of residential crisis stabilization and resolving systemic difficulties.
The Regional Data Technician distributes meeting notices and the meeting agenda. Minutes are recorded for each meeting and kept on file.

The Danville- Pittsylvania Partnership meets monthly on the first Thursday. Members include the:

- SVMHI facility director,

- SVMHI clinical services director,
- SVMHI medical director,
- DPCS behavioral health director,
- DPCS clinical services director,
- DRMC Behavioral Health Services director,
- DRMC social worker/case manager.

The Piedmont Partnership meets monthly on the second Wednesday. Its members include the:

- PCS behavioral health director,
- PCS clinical services director,
- PCS emergency services coordinator,
- PCS Lead ES clinicians for Patrick and Franklin Counties,
- PCS discharge liaisons,
- Martinsville Memorial Hospital Psychiatric Services director,
- MMH Psychiatric Services case manager,
- MMH emergency response team clinician,
- SVMHI clinical services director.
- MMH Chief Security Officer

PCS includes the City of Martinsville and the counties of Henry, Patrick and Franklin.

Danville-Pittsylvania Joint Emergency Services meets bi-monthly on the third Tuesday. Members include the:

- SVMHI clinical services director,
- SVMHI medical director
- DPCS behavioral health director,
- DPCS clinical services director
- DPCS Emergency Services Coordinator
- DPCS Residential Crisis Stabilization Services Coordinator
- DRMC Behavioral Health Services director,
- DRMC Behavioral Health Services medical director
- DRMC social worker/case manager.
- DRMC Emergency Department Director
- DRMC ED Medical Director
- Crisis Intervention Team (CIT) Coordinator
- Danville Police Department representative
- Danville City Sheriff and officers of the department
- Pittsylvania County Sheriff's Department representatives
- Chief Magistrate

Piedmont Joint Emergency Services meets bi-monthly on the second Thursday.

Members include the:

- PCS behavioral health director,
- PCS clinical services director,
- PCS emergency services coordinator,
- PCS Lead ES clinicians for Patrick and Franklin Counties
- PCS discharge liaisons
- Martinsville Memorial Hospital Psychiatric Services director,
- MMH Psychiatric Services case manager,

- MMH emergency response team clinician,
- SVMHI clinical services director.
- MMH Emergency Department Director
- CIT Coordinator
- Martinsville City Sheriff
- Henry County Sheriff's Department representative
- Patrick County Sheriff's Department representative
- MMH Chief Security Officer
- Chief Magistrates

The members represent Martinsville City and counties of Henry and Patrick.

Franklin County Joint Emergency Services meets quarterly on the first Thursday. Members include the:

- PCS-Franklin clinic manager
- PCS Lead ES clinician
- Carilion Franklin Memorial ED director
- Carilion Franklin Memorial medical director
- Franklin County Sheriff
- SVMHI clinical director
- SVMHI medical director
- Chief Magistrates

Southside Partnership/Joint Emergency Services meets bi-monthly on the third Thursday. Its members include the:

- Southside Community Services (SCS) Executive Director
- SCS behavioral health director
- SCS emergency services coordinator
- SCS discharge liaison
- ED director for Halifax Regional Hospital (South Boston)
- ED director for Southside Community Memorial Hospital (South Hill)
- Halifax County Sheriff's Department representative
- Mecklinburg County Sheriff's Department representative
- Brunswick County Sheriff's Department representative
- South Boston Police Department representative
- CIT coordinator
- SVMHI clinical services director

Management of the Clinical Course of Treatment and Length of Stay at SVMHI

SVMHI will continuously monitor the efficacy of treatment interventions and the efficient allocation of its internal resources in order to provide excellent quality of care, while minimizing individuals' length of stay.

SVMHI employs a utilization review coordinator who performs the following functions:

- Reviews each admission when the individual is covered by Medicare or other health insurance, when the individual is under 21 years old and covered by Medicaid and every fifth admission when the individual has no insurance coverage to determine whether the individual's

circumstances, at the time of his/her admission, met the criteria for medical necessity for inpatient care.

- Conducts reviews of individuals who are re-admitted within thirty days of the last discharge from SVMHI, individuals re-admitted within ninety days of the last discharge and individuals re-admitted to SVMHI three times within a year. The reviews consider multiple factors that may have contributed to the necessity for re-admission.

- When the individual's acute care stay is covered by Medicare, the utilization review coordinator will conduct scheduled reviews of the individual's continued stay. When a review indicates that the individual no longer meets the criteria for acute care, based on the Magellan criteria for continued stay, the attending psychiatrist will be notified. The psychiatrist may appeal the determination and, if appealed, the medical director will hear the appeal. If the psychiatrist accepts the determination, the individual will either be assessed to be clinically ready for discharge or assessed to require intermediate inpatient rehabilitative treatment. In either case, the individual will have non-acute status until discharged from the facility.

- Conducts reviews of individuals' course of treatment that have been treated for forty-five days and have not been assessed to be clinically ready for discharge. When a review indicates that the individual no longer meets criteria for continued stay, based on Magellan criteria for continued stay, the medical director and the attending psychiatrist will be notified. If the individual continues to meet the criteria for continued stay, the utilization review coordinator will schedule a multidisciplinary case consultation with the attending psychiatrist, who will invite key clinical staff, leadership staff and pharmacist to determine whether any changes in the treatment regimen may be indicated to improve the individual's progression to clinical stability. The multidisciplinary case consultation will consider if there are barriers to clinical stability and to affirm that all appropriate therapeutic measures and protocols are being applied to hasten clinical stability and discharge readiness. The attending psychiatrist will enter a summary of the consultation in the individual's medical record and forward a copy of the summary to the utilization review coordinator. After the individual has been in treatment for forty-five days and more, the utilization review coordinator will subsequently review the individual's progress monthly until the individual's discharge.

- The utilization review coordinator will schedule monthly meetings of the SVMHI Utilization Management Committee, comprised of the utilization review coordinator, medical director, psychiatrists, director of nursing, facility administrator, clinical services director, and director of social work. The agenda includes:

    10. Reports of the reviews for medical necessity of admissions during the previous month,
    11. Reviews of re-admissions,
    12. Reviews of individuals' length of stay exceeding forty-five days,
    13. Results of multidisciplinary case consultations,
    14. Review of the barriers to discharge of individuals on the Extraordinary Barriers to Discharge list and the progress made to resolve the barriers,
    15. Referrals to the regional residential crisis stabilization services
    16. Special focus studies
    17. RUM Committee report
    18. Other issues related to utilization management

The RUM Committee will review the Regional Utilization Management Plan during the fourth quarter of each fiscal year. Recommendations for amendments will be submitted to the SBHC for review and approval.

The SBHC approved the Protocols for Admissions to SVMHI on this day, March 10, 2014.

_____	_____
Jim Bebeau, Executive Director	Jim Tobin, Executive Director
Danville-Pittsylvania Community Services	Piedmont Community Services
SBHC Chairperson	
_____	_____
Don Burge, Executive Director	Daniel L. Herr. Facility Director
Southside Community Services	SVMHI